PHYSICIAN ASSOCIATES

ORLANDO HEALTH

FINANCIAL AGREEMENT

In consideration of the patient receiving services from Physician Associates, LLC, I agree:

- I am responsible for all expenses for treating the patient.
- Payment of charges is due at the time of the appointment.
- If Physician Associates files my insurance for me, I agree to pay for non-covered insurance benefits, co-insurance, co-pays and deductibles.

Patient Signature	Responsible Party's Signature (Parent/Guardian of Minor)
Printed Name	Printed Name
Date	Date

AUTHORIZATION TO RELEASE INFORMATION & TO PAY BENEFITS

I authorize Physician Associates, LLC to release any of my medical information, including drug and alcohol and HIV positive test results, to my insurance company(s), as needed to process my insurance claim.

I authorize my insurance company to make payments directly to Physician Associates, LLC for covered medical and/or surgical services.

Patient Signature	Responsible Party's Signature (Parent/Guardian of Minor)
Printed Name	Printed Name
Date	Date