

YOU MUST READ BELOW FOR IMPORTANT INFORMATION AND NOTICES

Financial Policy

I understand that I am financially responsible for all charges for services to me, including co-payments, co-insurance, out-of-pocket, deductibles and noncovered services.

I authorize the payments from my insurance company(s) according to my medical benefits be made payable to **Medical Associates of Brevard LLC** for professional services rendered. I understand that I will receive statements, reflecting my account balance and that the FINAL PAYMENT of this account is my responsibility. Furthermore, should I default on payment for services rendered I agree to pay all collection costs including reasonable attorney's fee. I authorize the disclosure of my medical information to all of Medical Associates of Brevard as well as to my insurance company(s).

LIFETIME SIGNATURE AUTHORIZATION: This signature and assignment is to be a continuing one, remaining in effect until revoked in writing by the undersigned. It signifies that all information given is current.

NOTE: You will electronically sign for this Financial Policy agreement on the signature pad in your doctors' office to be stored in your electronic medical chart.

Notice of Privacy Practices

I acknowledge that I have received a copy of the **Provider Notice of Privacy Practices** for Medical Associates of Brevard LLC. The Provider Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Provider Notice of Privacy Practices also describes my right and the responsibilities of duties of Medical Associates of Brevard with respect to my protected health information.

NOTE: You will electronically sign for this Notice of Privacy Practices on the signature pad in your doctors' office to be stored in your electronic medical chart.

Consent to Obtain External Prescription History

I authorize Medical Associates of Brevard LLC and its physicians and staff to view my external prescription history via the electronic medical records system Medent, and the Surescripts service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

NOTE: You will electronically sign for this Consent to Obtain External Prescription History on the signature pad in your doctors' office to be stored in your electronic medical chart. You will have the option to give consent or deny this access upon electronically signing.

Community Chart Consent

I give consent to Medical Associates of Brevard LLC to access the Community Chart in order to access and share my medical records if available through other entities operating under the Carequality Interoperability Framework, including Surescripts. This includes demographic information as well as other relevant clinical documentation.

NOTE: You will electronically sign for this Community Chart Consent on the signature pad in your doctors' office to be stored in your electronic medical chart. You will have the option to give consent or deny this access upon electronically signing.



CANCELLATION/NO SHOW/RESCHEDULING POLICY

We understand that situations arise in which you must cancel or reschedule your appointment. It is therefore requested that if you must change your appointment you provide more than 24 hours' notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellation or rescheduled appointments made less than 24 hours' notice, we are unable to offer that slot to other people.

Office appointments which are canceled or rescheduled with less than 24 hours notification may be subject to a **\$25.00 cancellation fee**.

Patients who do not show up for their appointment without a call to cancel an office appointment will be considered as **NO SHOW and may be subject to a \$25.00 cancellation fee**. Patients who no show two (2) or more times in a 12-month period, may be dismissed from the practice thus they will be denied any future appointments.

The cancellation, no show and rescheduling fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation, rescheduling and no-show fees should be directed to the billing department (321) 985-4200.

Please sign that you have read, understand and agree to the cancellation, rescheduling and no-show policy.

NOTE: You will electronically sign for this Cancellation/No Show/Rescheduling Policy agreement on the signature pad in your doctors' office to be stored in your electronic medical chart.