TLC Family Medical & Rehab Center

10205 W. Hillsborough Ave., Suite B, Tampa, Florida 33615
Phone: 813.884.2300 • Fax: 813.884.2390

11357 Countryway Boulevard, Tampa, Florida 33626
Phone: 813.925.8800 • Fax: 813.925.8840

Privacy Notices Form

Patient's Name: ______________________________

Date of birth: ______________

FOR MEDICARE PATIENTS:

I request that payment of Medicare benefits be made on my behalf to TLC Family Medical & Rehab Center for services provided. I authorize TLC Family Medical & Rehab Center to release any medical information necessary to my insurance in order to determine these benefits. I also request that my Medigap/or Secondary Plan benefits are made on my behalf to TLC Family Medical & Rehab Center for services provided. I authorize TLC Family Medical & Rehab Center to release any medical information needed to my insurance in order to determine these benefits.

FOR NON-MEDICARE PATIENTS:

I request that payment of authorized benefits be made on my behalf to TLC Family Medical & Rehab Center for any services provided. I authorize release of any medical information necessary to determine these benefits.

ALL PATIENTS:

I agree to be financially responsible for services provided as applicable. If participating, TLC Family Medical & Rehab Center agrees to file your claim to your insurance as provided. I understand that payment of services will not be delayed or withheld because of insurance discrepancies within my ability to correct. (e.g. coordination of benefits, terminated coverage, etc.) I understand that claims denied due to unfulfilled insurance requests will become my responsibility. TLC Family Medical & Rehab Center reserves the right not to accept corrected information after timely filing guidelines have expired. TLC Family Medical & Rehab Center agrees to file your secondary insurance plan, if applicable on a courtesy basis. I understand that balances remaining unsatisfied due to nonpayment from my secondary insurance plan may become my responsibility after 60 days. In the event that legal action should become necessary to collect an unpaid balance due, I agree to pay reasonable attorneys fees or other such costs as the Court determines proper.

NOTICE OF PRIVACY PRACTICES:

I acknowledge I have received the notice of privacy practices.

Patient/Guardian Signature: ______________________________ **Date:** ______________

Staff Member/Witness: ______________________________ **Date:** ______________

Reason for not obtaining Signature: ______________________________

This acknowledgement must be retained in patient's chart for 7 years from date of signature.