Jupiter Family Healthcare
Lori Lynn Dowie, D.O., P.A.
Tim Davis, PA-C
4600 Military Trail -Commons at Abacoa, Suite 122, Jupiter, FL 33458
Office: 561.743.4911 Fax: 561.743.2998 www.4myDO.com

STATEMENT OF FINANCIAL RESPONSIBILITY

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(Please name print clearly)

RELEASE OF INFO (MUST SIGN): I hereby authorize Jupiter Family Healthcare (Lori Lynn Dowie, D.O., P.A.) to disclose all or part of my records to any person or corporation which is required to pay for all or part of the health care center's and physician(s) charges, including but not limited to, insurance companies and workers compensation carriers. This authorization includes without limitation, release of the patient's medical records: present or future psychiatric, HIV tests, and substance abuse records.

______________ ______________________
Date Signature

LIFE TIME AUTHORIZATION (MEDICARE & MEDICAID MUST SIGN): I certify that the information given to me in applying for payment under Title XVIII and/ or Title XIX, of the Social Security Act is correct, and request that said payment of authorized benefits are made on my behalf. I understand that I am financially responsible for my health insurance deductibles, coinsurance and non-covered services. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicaid claim. I hereby irrevocably assign payment to Jupiter Family Healthcare (Lori Lynn Dowie, D.O., P.A.) and otherwise payable to me.

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Date Signature

AUTHORIZATION TO PAY BENEFITS (ANY INSURANCE MUST SIGN): I understand that Jupiter Family Healthcare (Lori Lynn Dowie, D.O., P.A.) will assist me in submitting my claim to my insurance carrier (if they are a provider of that insurance). I hereby authorize payment directly to Jupiter Family Healthcare (Lori Lynn Dowie, D.O., P.A.), otherwise payable to me, for the services provided. I understand that I am financially responsible for my health insurance deductibles, coinsurance and non-covered services.

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Date Signature

PAYMENT AND LAB BILLS (MUST SIGN): I hereby assume responsibility to pay the costs of all services provided by Jupiter Family Healthcare (Lori Lynn Dowie, D.O., P.A.) to the patient. I understand that the Jupiter Family Healthcare will utilize the laboratory required by my insurance; however the outside reference laboratory may bill me directly for all laboratory tests performed. I understand that a fee schedule (cost) for laboratory tests performed by Jupiter Family Healthcare (Lori Lynn Dowie, D.O., P.A.) shall be available to me upon request.

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Date Signature

CANCELLATION POLICIES (MUST SIGN): The office confirms appointments as a courtesy to our patients. All appointments require a 24 hour cancellation. We charge a fee of $25.00 for no-show or late cancel for a routine or follow up appointment. There is a fee of $50.00 for physicals, ultrasounds or surgical procedures. This is the patients' responsibility. You may cancel by phone during regular business hours only. We also accept cancellations by e-mail through our web site at www.4mydo.com.

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Date Signature

ADDITIONAL CHARGES (OPTIONAL BUT HIGHLY RECOMMEND): I have been informed that it is the patients' responsibility to pay any co-pays, deductibles or coinsurance per my insurance plan. I understand that I will receive a statement of any said balances due. I will subsequently have 30 days to remit the balance owed in the form of a check or money order.

In an effort to prevent my account from becoming delinquent or accruing any interest in the event that I fail to submit payment within the 30 days, I have chosen to guarantee payment with the credit card given below. It is my understanding that Jupiter Family Healthcare (Lori Lynn Dowie, D.O., P.A.) will charge the credit card given below my full balance ONLY AFTER the 30 days have lapsed, and subsequently I will receive a copy of my receipt by mail with a notice zero balance.

Account #:______________________ Circle one: VISA / MC Expiration date:__________ Sec Code:______

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Date Signature