ROBERT K. LAW, D.O., P.A.
3151 N. ALAFAYA TRAIL, S-101
ORLANDO, FLORIDA 32826

ADVANCED DIRECTIVES

(FOR COMPLIANCE WITH THE PATIENT SELF-DETERMINATION ACT)

NAME:_____ SS#_____

HAVE YOU EXECUTED AN ADVANCED DIRECTIVE? **Yes**_____ **No**_____

If YES, is this directive in the form of: _____ A Living Will
_____ Durable Power of Attorney
_____ A Health Care Surogate

If you have executed an advanced directive in any of the above formats, have you provided this office with a copy for your medical records? **Yes**_____ **No**_____

If you would like more information regarding advanced directives, please ask the nurse or receptionist.

I have been provided with information regarding the **PATIENT SELF DETERMINATION ACT**

SIGNATURE:_____ **DATE:**_____

Notice to all patients:

As a courtesy to our patients our office will file your primary and secondary insurance to the best of our efforts. When the insurance pays the patient directly we will expect payment at the time of service. We must set a time limit for payment, if your insurance has not paid within 90 days from the date of service the patient or guarantor will be responsible for payment in full for the medical services. Diagnostic and/or Laboratory tests will be billed separately.

Any medical service provided due to medical necessity and not covered by your insurance will be patient responsibility.

We **DO NOT** file insurance claims for Non-Contracted insurance companies. If we may assist you with any billing questions or payment arrangements, please contact out office. I agree to the above notice and my signature appears below.

_____ _____
PATIENT/GUARANTOR SIGNATURE **DATE**

Witness_____

LIFETIME AUTHORIZATION FOR MEDICARE Medicare#_____

I hereby request payment of authorized Medicare benefits and any other insurance benefits to be made either by me or on my behalf to Robert K. Law, D.O., P.A. for medical, diagnostic and laboratory services provided by the practice of Robert K. Law, D.O., P.A. I authorize Dr. Robert K. Law, D.O., P.A. to release to the Health Care Financing Administration and/or its agents any medical information needed to determine these benefits payable for related services.
Dr. Robert K. Law, D.O., P.A. agrees to accept the charge determination of Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and any non-covered charges.

_____ _____
PATIENT SIGNATURE **DATE**