AKLILU & COBIAN INFECTIOUS DISEASES, LLC
SIGNATURE ON FILE/AUTHORIZATION

COMMERCIAL AND MANAGED CARE MEMBERS

I authorize the release of any medical information necessary to process this claim. I authorize my doctor to act as my agent in helping me obtain payment payment from my insurnace companies. I authorize you to give me reasonable and proper medical care by today's standards. I authorize payment of medical benefits directly to Aklilu and Cobian Infectious Diseases, LLC for services rendered. I understand I am financially responsible for any balance not covered by my insurance carrier. I permit a copy of this authorization to be used in place of my original signature. Should this become a collection problem, the (client/debtor/patient) assumes all costs of collection, including but not limited to, court costs, interest, and legal fees.

Print Name: _____

Patient Signature: _____ Date: _____

MEDICARE/MEDICAID/MEDIGAP MEMBERS

I request that payment of authorized Medicare, Medicaid, and Medigap benefits be made to Aklilu and Cobian Infectious Diseaes, LLC for any services furnished to me by this group of physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I undersatnd my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on the other approved claim forms or electronically submitted claims, my signature authorizes release of information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare and Medicaid carrier as the full payement, and I, the patient, am responsible for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare and Medicaid carrier.

Print Name: _____

Patient Signature: _____ Date: _____

NO SHOW FEE

If a patient does not show to a scheduled appointment or does not call to cancel an appointment, after 3 times, there will be a $25 fee. This will apply to every appointment that was not cancelled in advance after the first 3 no shows.

Print Name: _____

Patient Signature: _____ Date: _____

ELECTRONIC MEDICATION/VACCINATION AUTHORIZATION

Aklilu and Cobian Infectious Diseases have gone to Electronic Medical Records (EMR). In doing so, we would need your permission in order to access your medications electronically from your pharmacy as well as your vaccination records from Florida SHOTS. This will ensure that our doctors will provide the best possible care.

Print Name: _____

Patient Signature: _____ Date: _____

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