Patient Consent & Final Acknowledgment

C Consent & Benefits

- ☐ I consent to medical evaluation and treatment by Altamonte Medical Associates, P.A.
- ☐ I authorize payment of insurance benefits directly to Altamonte Medical Associates, P.A. when applicable.
- ☐ I authorize release of information necessary for treatment, payment, and healthcare operations.
- ☐ I authorize communication regarding appointments, billing, care coordination, and practice communications through telephone, voicemail, text message, and email.

P Patient Responsibilities

- ☐ I will provide accurate and complete health information.
- ☐ I will notify the office if my insurance information changes.

✓ Final Patient Acknowledgment

- ☐ I certify that the information I have provided is accurate and complete to the best of my knowledge.
- ☐ I acknowledge that I have reviewed the policies and consents contained within this packet.
- ☐ I understand that I may request clarification regarding any portion of this packet.

Patient / Responsible Party Signature

Signature _____

Printed Name _____

Date _____ Relationship to Patient (if applicable) _____

Thank you for choosing Altamonte Medical Associates, P.A. Visit AltamonteMedical.com for office information and patient resources.