LifeForce Healthcare, LLC

Robert Zylis, APRN Jennifer J. Zylis, APRN
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Segismundo Pares, MD Gentana Lewis, APRN

PAYMENT POLICY

Your insurance policy is a contract between you and your insurance company. We file insurance claims as a courtesy to you. In the event that your insurance company does not pay their estimated amount or does not pay within 60 days, you are responsible for the unpaid balance. We send monthly statements to notify you of any co-payments, deductibles, or other fees that are your responsibility. If you have an unpaid balance in excess of 60 days past due, we reserve the right to apply a late fee. If your account is assigned to collection and/or suit, the prevailing party shall be entitled to reasonable attorney fees, cost of collections, and/or collection agency fees. There will be a $25.00 charge for any returned checks.

I agree to this financial policy and will be responsible for any payment due.

AUTHORIZATION OF TREATMENT

I hereby authorize the health care provider to render treatment.

AUTHORIZATION OF COMMUNICATION

Is there anyone we can speak to about your healthcare? ☐ Yes ☐ No

If yes, who? Name: _____ Relationship_____

Name: _____ Relationship_____

MEDICAL RELEASE

I certify the information I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their billing and collection agencies, including Medicare and Medicaid. I authorize payment of medical benefits to LifeForce Healthcare, LLC for services rendered.

Patient Name: _____DOB: _____

Name of Responsible Party: _____

Address: _____Phone: _____

Signature of Responsible Party: _____ Date: _____

Inquiries regarding any of this information should be directed to: LifeForce Healthcare, LLC
Attn: Office Manager – P.O. Box 773176 – Ocala, FL 34477
Phone: (352) 873-3800
Fax: (352) 873-4800