Authorization and Consent to Treat

1. Consent to Medical Treatment and/or Surgical Procedures: The undersigned consents to the medical and/or surgical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider, which may include but are not limited to laboratory procedures, X-ray examination, medical or surgical treatment or procedures, anesthesia or other services rendered the patient under the general and special instructions of the patient's physician. _____*(Initials)*

2. Assignment of Insurance Benefits and Authorization to Release Information: In consideration of services rendered, I hereby transfer and assign to Privia Medical Group Florida all rights, title and interest in any payment due to me for services rendered. Privia Medical Group Florida may disclose all or any part of my record (including psychiatric, alcohol and drug abuse in formation) to any part, person or corporation that is or may be liable under a contract to Privia Medical Group Florida or to my family member or employer for all or part of Privia Medical Group Florida's charge, including but not limited to medical service companies, insurance companies, workers' compensation carriers, welfare funds or my employer. _____*(Initials)*

3. Use of Copies: I permit a copy of these authorizations and assignments to be used in place of the original, which is on file with Privia Medical Group Florida.
This assignment will remain in effect until revoked by myself or an agent in writing _____*(Initials)*

4. Medicare/Medicaid: Patient's certification authorization to release information and payment request. I certify the information given to me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to Privia Medical Group Florida. _____*(Initials)*

5. Payment Responsibility: I understand certain insurance claims may be filed as a courtesy, however, if a claim is denied and deemed patient responsibility by the insurance company, I am responsible for payment. Insurance is considered a method of reimbursing the physician for services rendered to the patient. I understand it is my responsibility to pay any co-pay, deductible, co-insurance or any other balance not paid for by my insurance or third-party payer with a reasonable period of time. Please contact our customer service department at 321.434.5055 to discuss your payment options._____*(Initials)*

6. Financial Agreement - Self-Pay Only: The undersigned agrees, whether he/she sign s as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of Privia Medical Group Florida in accordance with the regular rates and terms of Privia Medical Group Florida. The undersigned certifies he/she has read the foregoing, receiving a copy thereof, and is the patient or is duly
authorized by the patient as patient's general agent to execute this document and accept its terms. _____*(Initials)*

7. Confidentiality: The undersigned agrees and understands that Privia Medical Group Florida entities have several electronic platforms, system s and applications that share information throughout our Integrated Delivery Network (" IDN ") where needed and permitted for treatment, payment and healthcare operations (TPO) and in accordance with applicable law. By virtue of signing this consent, Privia Medical Group Florida and its affiliated entities are permitted to share mental health and substance use and abuse information for treatment, payment and healthcare operations throughout its *IDN*_____*(initials)*

Notice of Privacy Practice Acknowledgement

I have received on this or a prior occasion the Privia Medical Group Florida Notice of Privacy Practices and acknowledge I have a copy of requested and was given a copy.

Received copy this date: ☐ Yes ☐ No Previously received copy: ☐ Yes ☐ No ☐ Patient declined copy

☐ Patient unable to acknowledge receipt of Notice of Privacy Practice Reason:_____

I authorize Privia Medical Group Florida and all of its affiliated entities, employees and Independent Contractors permission to call me through the use of dialing equipment, artificial voice or similar technology, even if I am charged for the call. I expressly agree that such automated calls may be made by Privia Medical Group Florida and all of its affiliates, contractors and agents. I expressly consent to such automated calls and with such consent, I specifically waive any claim I may have against Privia Medical Group Florida and all of its affiliates, contractors, employees or agents for making of such calls, including any claim under the Telephone Consumer Protection Act. I also expressly agree that this provision applies to the use of text messaging. I authorize Privia Medical Group Florida and all of its contractors, affiliates and agents to use any cell phone or other telephone number to contact me for any purpose, including outstanding bills.

Print name_____ DOB_____

Signature_____ Date_____

Signature if different from patient_____
(proxy/agent or guardian if patient is under 18)