

**University Family Medicine Center PA  
10055 University Blvd Orl, FL 32817  
407-679-4800**

## **Financial Agreement**

In consideration of the patient receiving services from University Family Medicine, I am responsible for all expenses for treating the patient.

Payment of charges is due at the time of service.

If University Family Medicine files my insurance for me, I agree to pay for non-covered insurance benefits, co-insurance, co-pays and deductibles.

I authorize University Family Medicine to release any of my medical information, including drug and alcohol and HIV positive test results, to my insurance company(s), as needed to process my insurance claim.

I authorize my insurance company to make payments directly to University Family Medicine Center for covered medical and/or surgical services

Name \_\_\_\_\_ Date \_\_\_\_\_