# Apollo Beach Family Medical Center Telemedicine Financial Agreement

In consideration of the patient receiving services from Apollo Beach Family Medical Center I agree:

- I am responsible for all expenses for treating the patient
- Payment of charges is due at the time of appointment
- If ABFMC files my insurance for me, I agree to pay for non covered insurance benefits, coinsurance, copays and deductibles.

**Authorization to Release Information & To Pay Benefits**

I authorize ABFMC to release any of my medical information, including drug and alcohol and HIV positive test results to my insurance company, as needed to process my insurance claim. I authorize my insurance company to make payments directly to Apollo Beach Family Medical Center for covered medical services.

Signature of Patient/Authorized Representative:
Print Patient Name:
Date:

**Cancellations/No Show appointment Policy**

Apollo Beach Family Medical Center has an established no show policy. This policy is designed to insure Apollo Beach Family Medical Center can give service to as many patients as possible, and is in no way designed to be punitive to patients who have been, or are, responsible when it comes to scheduling and keeping their appointments. A charge of $25.00 will be charged to your account for any appointment not cancelled within 24 hours of your scheduled date.

Signature of Patient/ Authorized Representative:
Print Patient Name:
Date: