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Legal Waiver

I, _____, understand that some physicians employed by and/or affiliated with Florida Heart and Vascular, LLC ("FHV") may not have a contract with the insurance company from which I receive my health coverage (i.e., the physician is "out of network"). I also understand that I have the right to ask FLAHRS if the Physician providing my care has a contract with my insurance company. I have either exercised or waived my right to receive services provided on _____.

Waiver of My Rights:
___ I voluntarily waive the foregoing and expressly permit FLAHRS to bill me for the total amount, or any partial amount, of my bill, regardless of whether my physician has received prior authorization for treatment from my insurance company.

___ ***Due to this waiver, I understand and acknowledge that FLAHRS will charge me its standard charges for the care provided. That charge may be higher than I would pay if I were to elect an in-network contracted provider (i.e., a physician with a contract with my insurance company). I am expressly waiving these rights because I prefer to receive my care from physicians at FLAHRS. I understand and acknowledge that there are other qualified doctors in the area from whom I could seek treatment, some of whom may accept my health insurance, thereby reducing the overall cost of the healthcare service I want to receive.***

___ I have been allowed to ask questions, and all of my questions have been answered fully and satisfactorily. I confirm that I have read and fully understand the above, including the fact that I am waiving certain legal rights to which I am otherwise entitled. I acknowledge that I have signed this waiver freely and in the absence of any coercion or duress.

_____ _____
Patient Signature Witness Signature

_____ _____
Patient Name Witness Name

Date: _____