Family Care Partners - Patient Policies

NAME OF PATIENT	DATE OF BIRTH

AUTHORIZATION:

I HEREBY AUTHORIZE THE OFFICES AND EMPLOYEES OF FAMILY CARE PARTNERS OR ITS CONTRACTED SERVICE COMPANIES TO RELEASE INFORMATION NECESSARY TO PROCESS CLAIMS WITH MY INSURANCE COMPANIES, AND FURTHER AUTHORIZE PAYMENT OF INSURANCE BENEFITS DIRECTLY TO SAME.

FINANCIAL RESPONSIBILITY:

UPON ACCEPTANCE OF TREATMENT IN THIS OFFICE, I ASSUME FINANCIAL RESPONSBILITY FOR PAYMENT OR FEES.

OUR ADDITIONAL SERVICES TO YOU:

AS COURTESY TO OUR PATIENTS, WE ARE HAPPY TO FILE INSURANCE FORMS AND WILL ACCEPT ASSIGNMENT OF INSURANCE BENEFITS.

FEES NOT COVERED BY INSURANCE:

DEDUCTIBLES AND CO-PAYMENT (THE PORTION OF OUR FEES NOT COVERED BY INSURANCE) **MUST BE PAID AT THE TIME TREATMENT IS RENDERED.** THIS MAY BE IN THE FORM OF CASH, CHECK, VISA OR MASTERCARD. YOU WILL BE RESPONSIBLE FOR ANY RETURNED CHECK FEES THAT MAY BE INCURRED.

CONSENT FOR TREATMENT:

PERMISSION IS HEREBY GIVEN TO THE PHYSICIANS AND STAFF OF FAMILY CARE PARTNERS TO PROVIDE ORDINARY AND NECESSARY MEDICAL EXAMINATION, DIAGNOSIS, AND TREATMENT AND ADMINISTER SUCH THERAPEUTIC TREATMENT OR SERVICES THAT THE PHYSICIAN MAY ORDER. ORDINARY AND NECESSARY MEDICAL CARE SHALL INCLUDE PREVENTIVE AND PROPHYLACTIC CARE AS WELL AS LABORATORY TESTS BUT SHALL NOT INCLUDE SURGERY, GENERAL ANESTHESIA, LABORATORY TESTS FOR WHICH SEPARATE CONSENT IS REQUIRED UNDER THE LAW OR OTHER EXTRAORDINARY PROCEDURES. I FURTHER CONSENT TO ROUTINE IMMUNIZATIONS FOR FUTURE OFFICE VISITS.

NON-PAYMENT:

IN THE EVENT IT SHOULD BECOME NECESSARY TO PLACE YOUR ACCOUNT IN THE HANDS OF AN ATTORNEY OR COLLECTION AGENCY, YOU WILL BE RESPONSIBLE TO PAY ALL COSTS OF COLLECTION, INCLUDING ATTORNEY'S FEES.

PATIENT OR GUARDIAN SIGNATURE	
PRINTED NAME OF SIGNER (IF DIFFERENT FROM PATIENT NAME)	DATE