Patient's Full Name: _____ D.O.B.: _____

FamilyCare OF MIDDLE GEORGIA

Patient Authorization for use and Disclosure of Protected Health Information & Patient Rules and Responsibility

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Family Care of Middle Georgia to use and/or disclose certain protected healtH information (PHI) about me to the following Person or Entity to Receive the Information: (please list other medical providers, family, friends, etc. who may receive your medical information.

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____

____ (Initial) I understand that this authorization may include disclosure of information relating to alcohol and drug abuse, mental health treatment, except psychotherapy notes, and confidential HIV-related information unless I exclude this information above. In the event my health information includes any of these types of information, I specifically authorize release of such information to the person(s) indicated above.

PAYMENT

I hereby authorize direct payment of medical benefits to Family Care of Middle Georgia for services rendered. I consent to the use or disclosure of my protected health information by Family Care of Middle Georgia and if needed information from other providers, for the purpose of obtaining payment for my health care bills or to conduct the healthcare operations.

I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by my contract with my insurance plan. I understand that I am financially responsible for making payment for any balance not covered by my insurance at time of service or upon receipt of a billing statement from Family Care of Middle Georgia. Failure to pay for the services will result in collection actions being taken to collect the debt (i.e. being sent to a collection agency).

All copays are due at time of visit. If you have no insurance, then you would be required to pay for the cost of the office visit before being seen.

CANCELLATION POLICY

If you are unable to make your appointment, you must notify our office one day (24 hours) prior to the appointment or you will be charged a no show fee. If you miss an appointment, you will be charged **$20**. The no show fee must be paid prior to being scheduled for another appointment.

NO SHOWS - *1, 2, 3 strikes you're out*

If you miss a new patient appointment twice, you will not be rescheduled. And, if you have 3 no shows throughout the past 12 months, we will no longer be your PCP, you will not be able to make an appointment with us but you can try to come in as a walk in.

I have read, understand, and agree to the provisions of this Patient Responsibility form.

Printed name of patient or legal guardian: _____ Date: _____

Signature of patient or legal guardian: _____ Relationship: _____