



SIGN-IN# / TIME: \_\_\_\_\_  
SYMPTOMS: \_\_\_\_\_

**PATIENT CONSENT**

**CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS**

I consent to the use or disclosure of my protected health information by First Care for the purpose of diagnosing or treating me, obtaining payment for healthcare bills, or conducting healthcare operations of First Care. I understand that my diagnosis or treatment by First Care may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed for purposes of treatment, payment, or healthcare operations. First Care is not required to agree to the restrictions that I may request. However, if First Care agrees to a restriction that I request, the restriction is binding on First Care.

I have the right to revoke this consent, in writing, at any time, except to the extent that First Care has taken action in reliance on this consent.

My "protected health information" means information, including my demographic information, collected from me and documented or received by my physician, another healthcare provider, a health plan, my employer, or a healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition and identifies me (or there is reason to believe the information may identify me).

I understand I have the right to review the First Care Notice of Privacy Practices prior to signing this document. The First Care Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur for purposes of treatment, payment, and healthcare operations of First Care. The Notice of Privacy Practices for First Care is available at the front desk and at the First Care website, www.firstcaremd.com. The Notice of Privacy Practices also describes my rights as well as First Care duties with respect to my protected health information.

First Care reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised copy from the First Care website or by requesting a revised copy by mail or in person.

**AUTHORIZATION FOR INSURANCE ASSIGNMENT AND PHYSICIAN OR NURSE PRACTITIONER PAYMENT**

I hereby assign all insurance benefits to First Care. I understand that I am responsible to First Care for my and my family's individual charges incurred during the course of treatment even though I may have insurance or third party coverage. I recognize that First Care maintains insurance contracts with Blue Cross and Blue Shield of Alabama, Medicare, and Phifer Wire. I understand that while First Care may file claims to other non-Medicaid and non-ChampVA insurance carriers, these carriers consider First Care to be "out-of-network" and may not cover most or all of my charges. I also understand that my insurance carrier (whether in-network or out-of-network) may not cover Nurse Practitioners. I acknowledge full responsibility for understanding the terms of my insurance policy and I promise to pay any remaining balance when due. In the event of default, I recognize that legal proceedings my result and I agree to pay all collection costs, including reasonable attorney's fees.

I understand that certain insurance carriers and health maintenance organizations require a referral from the designated primary care physician prior to being seen by First Care. It is my responsibility to secure this authorization. I understand that if the referral was not secured or not approved that I am responsible for all charges. Any charges rejected as non-covered are also my responsibility.

I understand that if I am uninsured, I will be required to pay a minimum fee established by First Care prior to my treatment. I further understand that I will be billed for any additional charges beyond the aforementioned minimum fee that are incurred during the course of my treatment.

**I AGREE TO THE ABOVE CONSENT AND AUTHORIZATION:**

\_\_\_\_\_  
Patient's Name  
\_\_\_\_\_  
Today's Date  
\_\_\_\_\_  
Current Address  
\_\_\_\_\_  
Apt/Lot #  
\_\_\_\_\_  
City                      State      Zip  
\_\_\_\_\_  
Home Phone              Work Phone

\_\_\_\_\_  
Patient or Authorized Signature  
\_\_\_\_\_  
Relationship to Patient  
\_\_\_\_\_  
Current Insurance Company  
\_\_\_\_\_  
Policy Holder's Name  
\_\_\_\_\_  
Policy Holder's Date of Birth  
\_\_\_\_\_  
Policy Holder's Relationship to Patient