Signature on File: You are hereby authorized to give to my Health Insurance Company or any representative thereof, any and all information which may be requested regarding my physical condition and treatment rendered, or records which you may have regarding my condition or treatment. I understand that I am financially responsible for all charges incurred in my behalf. If required, this authorization meets the Medicare Signature on File Requirement. I UNDERSTAND THAT THIS REMAINS IN EFFECT UNTIL REVOKED IN WRITING.

Initials_____

Assignment of Insurance Benefit: I hereby authorize payment directly to provider named above of all medical insurance benefits including Major Medical payments otherwise payable to me. ***I understand that I am financially responsible for all charges including any labs, tests or procedures not covered under my insurance plan or plans and/or excess of the benefits paid under such plan or plans.*** A photographic copy of this authorization shall be valid as the original. I UNDERSTAND THAT THIS REMAINS IN EFFECT UNTIL REVOKED IN WRITING.

Initials_____

***Payment Policy*:** Co-Insurance amounts, Co-Payment amounts and/or deductibles are due at time of visit. Patients are responsible for all charges that are not covered by insurance or not paid in full by insurance. Payments are due on all accounts at FAMILY MEDICAL CLINIC OF CHUBBUCK every 30 days, you may be charged 18% interest APR. You may be charged a $20.00 inconvenience fee for any payment that does not process through the bank. **Kindly give 24 hour notice if you need to change your appointment, anything cancelled same day may count as a no show. Due to our busy appointment schedules; if you have an appointment and do not show or call to reschedule or cancel, you will be responsible for the following before you are scheduled again: 1st no show no fee, 2nd no show $10.00 fee, 3rd now show $15.00 fee, 4th no show $20.00 fee. These fees are cumulative. Payment for no shows must be satisfied before scheduling subsequent appointments. If you have questions please ask our staff.

Initials_____

Acknowledgement of Notice of Privacy Practices:

A copy of the Notice of Privacy Practices for Family Medical Clinic of Chubbuck has been made available to me detailing how my information may be used and disclosed as permitted under federal and state law.

Initials_____

Printed Name_____
Signature_____
Date_____

If patient is a minor or you have POWER OF ATTORNEY for this patient, please complete the following as it applies to all of the above and provide a copy of POWER OF ATTORNEY documentation.

Patient Printed Name: _____
YOUR Printed Name: _____
YOUR Signature: _____
YOUR Relationship to patient: _____
Signature Date: _____