

# Avance Care – New Patient Registration Disclosures and Consents

Patients or legal guardians for minor child MUST sign and date all paragraphs below before medical care can be rendered.

## PATIENT INFORMATION

Legal Name: (First) (Middle) (Last)

Date of Birth:

### ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Avance Care, P.A., or the physician individually, for services rendered to my dependents or to me by the physician or a clinician under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-payments, co-insurance, deductibles or balances due that are my responsibility for payment either at the time of service or after being notified that Avance Care, P.A. is unable to collect from my insurance carrier for whatever reason.

### FINANCIAL RESPONSIBILITY:

I certify that I have received, read and understood a copy of the Avance Care Patient Financial Policy - *effective date of May 1, 2008*. I also understand that I am ultimately responsible for the charges incurred by me or by my child/children as their legal parent or guardian. Therefore, knowing this, I request that services be performed and I agree to be responsible for any charges incurred. I understand that if I fail to make payment when due and my account becomes delinquent or is turned over to a collection agency or attorney for collections, that I undersigned shall pay all collection agency fees, court costs and attorney fees, and risk being dismissed from the physician care of Avance Care, P.A.

For Self-Pay patients, I also understand that I am responsible for all services rendered to my dependents or myself at the time of service.

This consent will remain in effect from the date signed below until revoked in writing. No additional notification, authorization, or consent will be deemed necessary for each time of service.

### MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Avance Care, P.A. or the physician on my behalf.

### AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of Avance Care Notice of Privacy Practices. I hereby authorize Avance Care, P.A. or the physician individually to release any of mine or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation or the processing of insurance benefits.

### AUTHORIZATION TO MAIL, CALL OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls and e-mail. I hereby authorize the Avance Care, P.A. representative or my physician to mail, call or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Avance Care, P.A. to that effect in writing.

### LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services from another facility. I further understand that I am financially responsible for any co-payment, co-insurance, deductible or balance due for these services if they are not reimbursed by my insurance for whatever reason.

### ADDITIONAL FEES FOR EXTENDED HOURS SERVICE:

I understand that Avance Care, P.A. may charge additional fees (not to exceed \$50) to help compensate for higher operating costs for visits during evenings (after 6PM), weekends, and holidays. This fee is added to the baseline charges for the visit.

### CONSENT TO TREATMENT:

I hereby consent to evaluation, testing and treatment for me or my dependents as directed by my physician or his or her designee at Avance Care.

**PATIENT SIGNATURE:** \_\_\_\_\_  
(or Legal Guardian, for minor patient)

**DATE:** \_\_\_\_\_

**PRINT NAME:** \_\_\_\_\_

**GUARANTOR SIGNATURE:** \_\_\_\_\_  
(If different from patient)

**DATE:** \_\_\_\_\_

**GUARANTOR NAME:** \_\_\_\_\_