Avance Care – Demographics

Today's Date	

PATIENT INFORMATION

Patient Full Legal Name (Last) (First) (Middle)					Date of Birth:
Address (Street Number) (Street Name) (Apt. No.)					
City	State	Zip	Cell Phone Number	Gender Assigned at Birth: ☐ Male ☐ Female ☐ Other	Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
E-Mail Address	Occupation			Employer Name & Address	

Sexual Orientation Name:	Gender Identity:	How Did You Hear About Us?
☐ Lesbian, gay, or homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Do not know. ☐ Choose not to disclose. ☐ Something else, please describe: _____	☐ Male ☐ Female ☐ Female-to-Male (FTM) / Transgender Male/Trans Man ☐ Male-to-Female (MTF) / Transgender Female/Trans Woman ☐ Genderqueer, neither exclusively male nor female ☐ Choose not to disclose. ☐ Additional gender category or other, please specify: _____	☐ Internet ☐ Friends/Family Member ☐ Insurance Plan Directory ☐ Driving By ☐ Advertisement ☐ Another Doctor ☐ Other

Language: ☐ English ☐ Spanish ☐ Other _____	Ethnicity ☐ Hispanic ☐ Non- Hispanic ☐ Other: _____	Race: ☐ African American ☐ Japenese ☐ Vietnamese ☐ American Indian ☐ Korean ☐ White/Caucasian ☐ Asian Indian ☐ Native Hawaiian ☐ Other: _____ ☐ Chinese ☐ Other Asian ☐ Filipino ☐ Vietnamese

Parent or Legal Guardian (Only for Patient under 18 years of age - List person responsible for bill – use full legal name, no nicknames)

Full Legal Name (Last) (First) (Middle)			
Date of Birth	Phone Number	Gender: ☐ Male ☐ Female	Relationship to Patient (please specify): ☐ Self ☐ Spouse ☐ Parent ☐ Other
Address (If Different from Above)	City	State	Zip Code

INSURANCE INFORMATION (Please allow receptionist to photocopy your insurance ID cards)

Primary Insurance Company Name *(if no insurance, please indicated "Self-Pay")*	Policy ID Number:	Group No.	Effective Date:
Subscriber Name	Relationship: ☐ Self ☐ Spouse ☐ Parent ☐ Other (please specify)	Social Security No. **NOT COLLECTED**	Date of Birth
Secondary Insurance Company Name:	Policy ID Number:	Group No.	Effective Date:
Subscriber Name	Relationship: ☐ Self ☐ Spouse ☐ Parent ☐ Other (please specify)	Social Security No. **NOT COLLECTED**	Date of Birth

EMERGENCY INFORMATION

Person to Notify in Case of Emergency		Relationship: ☐ Spouse ☐ Parent ☐ Other _____
Home Phone	Business Phone	Cell Phone
Address (If Different from Above)	City	State & Zip Code

PHARMACY YOU PREFER TO USE

Name:	Address:	Phone:

CERTIFICATION & AUTHORIZATION

I certify that all the above information is correct. I authorize the release of any information concerning my or my child's health care, advice and treatment provided for the purpose of evaluating and administrating claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to Avance Care, P.A.

Signature of Patient or Parent of minor or Legal Guardian:	
Name	Date:

AvanceCare

DISCLOSURE AND CONSENT

The following is an agreement between you, the patient or responsible party, and Avance Care, P.A. ("Avance Care"). Please read each of the terms and authorizations in this agreement carefully. If you have questions about this agreement, please ask your provider or Avance Care staff for clarification.

1. **GENERAL CONSENT TO TREATMENT:** I hereby consent to and authorize Avance Care, its physicians, licensed independent practitioners, employees, contractors, and other agents involved in my care to administer such evaluation, testing and treatment for me or my dependent(s) as may be deemed medically reasonable by the health care providers caring for me or my dependent(s) at Avance Care ("Avance Care Providers"). I understand the services may include lab tests, screening tests, diagnostic tests, and routine exams. In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by Avance Care Providers. I further understand and acknowledge that no guarantee, promise, or other assurance has been made to me regarding the effect, result, or outcome of any test, examination, treatment or other services that I or my dependents may receive at Avance Care.

2. **NOTICE OF PRIVACY PRACTICES AND PERMITTED DISCLOSURES:** I certify that I have received, read, and understand Avance Care's Notice of Privacy Practices. I understand that the Notice of Privacy Practices is available to me for review in the office or at any time through Avance Care's website.

3. **AUTHORIZATION TO MAIL, TEXT, CALL OR E-MAIL:** I hereby authorize Avance Care representatives, my provider, or FastMed's representatives to mail, text, call or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, laboratory results, general healthcare education or announcements, or financial information regarding my services, including insurance claims. As further explained in Avance Care's Notice of Privacy Practices, FastMed is Avance Care's partner in a shared instance of Epic (the electronic medical records serving both organizations).

4. **ASSIGNMENT OF BENEFITS:** I hereby authorize direct payment of my insurance benefits to Avance Care, P.A., or the providers individually, for services rendered to my dependent(s) or to me by the physician or a clinician under their supervision. In the event that Avance Care does not accept assignment of my insurance benefits, I am aware that some, and perhaps all, of the services provided may be considered non-covered services under my insurance plan, and I acknowledge and agree that I will be fully responsible for any such charges.

5. **MEDICARE 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 provider on my behalf.

6. **CO-PAYS; CO-INSURANCE; DEDUCTIBLES:** I understand that I will be responsible for the timely payment of any co-payments, co-insurance, deductibles or balances due on my account and that Avance Care may require a $150 minimum deposit prior to me or my dependent being seen by a provider if I have not met my deductible or if I have a high deductible plan.

7. **SELF-PAY AND OUT-OF-NETWORK PATIENTS:** I understand that I will be expected to pay the amounts due for services received at Avance Care in full at the time of service if (i) I do not have insurance; (ii) Avance Care or my individual provider does not participate with my health insurance plan; (iii) I am unable to present a valid and accurate member identification card from my health insurance plan at the time of my visit; or (iv) Avance Care is unable to verify my health insurance coverage. In accordance with federal price transparency guidelines, self-pay patients are able to receive an estimate of charges for services prior to their visit. Estimates can be requested through MyChart, at the time of scheduling, or in person during check-in. Please note that the initial estimate is subject to change if additional services are requested and agreed upon by the patient during the visit. The estimate provided is for informational purposes only, and actual charges may vary based on the services rendered. Payment of the estimated amount is expected at the time of service.

8. **BILLING INFORMATION AND INSTRUCTIONS:** I agree to bring and provide Avance Care with a current copy of my health insurance card at each of my visits. I understand that I am responsible for ensuring that the billing information that I provide to Avance Care and that Avance Care will not be held liable for ensuring the accuracy of my insurance information. If I choose to not use my insurance and do not want my claims filed to my health insurance provider, I understand that I must inform the staff at the front desk of this decision prior to the time of my appointment and pay my bill in full at the time of service. If I do not inform Avance Care of my preference to not use my health insurance before my appointment time, I understand and agree that my claim will automatically be billed out to the insurance company that Avance Care has on file for me.

9. **ON-THE-JOB INJURIES:** I understand that Avance Care does not participate in Workman's Compensation insurance, and that if the reason for my visit is an accident or injury while on the job, I will be responsible for paying all charges at the time of service. I understand that I may request, and Avance Care will provide to me upon such request, a detailed receipt that I may file separately for reimbursement from my insurance carrier.

10. **PAYMENTS; LATE FEES; COLLECTIONS:** Avance Care accepts payments by cash and credit card. I understand that any such fees that are not paid on the date of my visit will be subject to a $20.00 late fee. If I have a balance on my account, I understand that Avance Care will send me a statement that details any previous balance, any new charges to my account, and any payment or credits applied to my account during the preceding month. I agree to pay any charges listed on a statement either online or by mail within 30 days of the date on such statement. If I have a credit card on file with Avance Care, I hereby authorize Avance Care to charge any unpaid balance on my account to the credit card on file on the date that is 30 days after the first statement date. It is my responsibility to inform Avance Care if I do not wish to pay the balance with my credit card on file. I understand that failure to pay my account balance within 30 days from the date on the applicable statement may result in interest charges up to the maximum amount allowed by law and an additional late fee of $20.00. After 90 days, Avance Care will turn over any past due balance that has not been paid to a collections agency. I understand that if my account becomes past-due and/or is turned over to a collections agency, that I, the undersigned, shall be solely responsible for and obligated to pay all collection agency fees, court costs and attorney fees associated with Avance Care's collection of my delinquent balance. I further understand that failure to make payments in a timely manner may put me or my dependent(s) at risk of being dismissed as patients of Avance Care, P.A.

11. **PAYMENT FOR TREATMENT OF MINORS**: Please be aware that for any treatments provided to minor dependents, Avance Care will charge all any fees to the parent authorizing treatment for the minor dependent and such authorizing parent shall be responsible for the payment of any such charges in accordance with the terms in this agreement. It is the sole responsibility of the authorizing parent to collect any amounts that another party may be obligated to pay in connection with a minor dependent's treatment pursuant to a divorce decree or other legal agreement.

12. **LAB/X-RAY/DIAGNOSTIC SERVICES:** I understand that Avance Care may use an outside lab or facility to perform certain services in connection with my treatment (each an "Outside Facility") and that such Outside Facilities are not associated with Avance Care. I understand that I am not obligated to use any particular Outside Facility and have the right to choose to use other Outside Facilities in the area. I understand that it is my responsibility to check with my insurance company to see if the Outside Facility where I receive diagnostic tests or services is covered under my insurance plan and that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services from an Outside Facility. I further understand that I am financially responsible for any co-payment, co-insurance, deductible or balance due for any services provided by an Outside Facility if they are not reimbursed by my insurance for whatever reason.

13. **ADDITIONAL FEES FOR EXTENDED HOURS SERVICE:** I acknowledge and understand that Avance Care may apply additional fees for services rendered during Extended Hours, which may include times after 5:00 pm on weekdays, weekends, and recognized holidays. I further understand that additional fees may also apply to telephone or other remote consultations provided to me or my dependents during these Extended Hours. These fees may be submitted to my insurance provider, if applicable, and I agree to be responsible for any portion not covered and to pay such fees in accordance with the terms of this agreement.

14. **MISSED APPOINTMENTS**: I understand that Avance Care may charge me a "no-show fee" for any missed appointments unless I cancel or re-schedule such visit at least 24 hours in advance of my scheduled appointment time. Avance Care will not file any no-show fees to any insurance carrier, and I agree to be responsible for payment of any no-show fees for appointments that I fail to cancel or re-schedule at least 24 hours in advance.

15. **IDENTIFICATION AND PHOTOGRAPHY:** I understand that accurate identification of patients and staff promotes patient safety, security, and privacy. I, therefore, understand that I may be asked for identification, including but not limited to photo identification, at various points throughout my treatment at Avance Care. I, further, agree that Avance Care may photograph me for identification or treatment purposes. Any such photographs will be maintained in accordance with applicable Avance Care policy.

16. **REVOCATION OF CONSENT:** I understand that I may revoke or discontinue my consent at any time by notifying Avance Care in writing, except to the extent actions have already been taken based upon my consent.

THE UNDERSIGNED, CERTIFIES THAT THEY HAVE READ AND UNDERSTAND EACH OF THE ABOVE AUTHORIZATIONS AND TERMS INCLUDED IN THIS AGREEMENT.

Patient Signature: _____ **Date**: _____
(or Legal Guardian, for Minor Patient)

Patient Name: _____ **Date of Birth**: _____

Legal Guardian Name: _____ **Relationship**: _____
(if authorizing treatment for minor patient)

AvanceCare

Patient Rights and Responsibilities

To provide and receive the highest quality care at Avance Care, the patient and the provider must have a relationship of mutual respect. Join us as active members of your health care team by reviewing the rights and responsibilities listed below for patients and patient representatives.

Patients have the right to:

- Receive prompt, respectful, and quality care and treatment, administered with comfort and consideration.
- Access health services without discrimination based upon race, religion, sexual orientation, gender identity, national origin, or source of payment.
- Privacy and confidentiality when seeking or receiving care, to the extent permitted by law.
- Confidentiality of your health records, to the extent permitted by law.
- Receive accurate information concerning diagnosis, treatment, risks involved, and prognosis of an illness or health-related condition, in terms that you can understand (including use of an interpreter, if needed).
- Receive information you can understand, including the access to an interpreter and/or translation services at no charge.
- Participate in decisions regarding your medical care and treatment, including providing informed consent prior to any procedure or treatment in non-emergency circumstances.
- Refuse any drugs, treatment, or procedure offered by your provider.
- Inquire and receive information about reasonable alternatives to care.
- Reach out for a second professional opinion regarding your health care and treatment.
- Request and receive the name and roles of any health care personnel participating in your care.
- Be informed of, and freely exercise, the option to refuse participation in any research aspect of your care without compromising access to medical care and treatment.
- Receive information about your coverage or cost of visit if uninsured.
- Receive and examine a detailed explanation of your bill and be informed of any known financial resources for your health care.
- Be informed about any legal reporting requirements regarding any aspect of screening or care.
- Know what clinic rules and regulations apply to your conduct as a patient.
- Have access to an individual or agency who is authorized to act on your behalf to assert or protect your rights.

If someone is helping you make healthcare decisions, he or she may exercise these rights for you.

Patients have the responsibility to:

- Provide complete and forthcoming information regarding all illness(es) or problem(s), to allow us to properly evaluate and treat.
- Provide a complete medical history, to the best of your ability.
- Ask questions, communicate concerns, and actively participate and cooperate in your treatment plan(s). Let us know if you don't understand the information we give you about your condition or treatment.
- Take responsibility for the consequences of refusing care or not following instructions.
- Inform your medical provider if your condition worsens, or an unexpected reaction occurs.
- Show respect to all staff, other patients, and the medical team.
- Be aware of and refrain from behavior that unreasonably places others' health and safety at risk.
- Respect other patients' right to privacy while in our clinics.
- Ensure that you do not violate another patient's right to privacy by recording or otherwise electronically capturing another patient's image or voice while in our clinics.
- Follow the rules and regulations of our clinics.
- Present your insurance information at the time of service.

- Know your coverage and benefit information for services.
- Attend your appointments or reschedule/cancel an appointment within a reasonable time frame to avoid no-show charges.
- Make payment at the time of service and pay outstanding balances.
- Use prescriptions or medical devices for yourself only, and not knowingly participate in medical fraud.
- Report illegal or unethical behavior by health care personnel.

Concerns or Complaints

Central to our efforts is the delivery of high-quality care to our patients along with exceptional customer service. In addition, please be assured that we acknowledge and support the rights and responsibilities of our patients at Avance Care. If you have a concern, complaint, grievance, or believe your rights have been violated, please speak with your caregiver or the Office Manager on site. You may also call 919-237-1337 (option 8) after hours and leave a message, where you will receive a return call promptly. We would appreciate the opportunity to resolve any concerns that might arise--in particular quality or patient safety issues.

The rights and responsibilities outlined herein are based on and supported by various rules, regulations, and guidance issued by State and Federal agencies.

Attestation

By signing this statement, I acknowledge that I have reviewed the Patient Rights and Responsibilities document, and thus have been informed of my rights and responsibilities as a patient of Avance Care. I understand the information provided and agree to uphold my responsibilities while receiving care at Avance Care. I understand that if I fail to meet the responsibilities outlined or engage in behavior that is disruptive, disrespectful, or non-compliant with clinic policies, Avance Care reserves the right to terminate the patient-provider relationship, consistent with applicable laws.

Patient or Legal Representative (Please print)	
Signature	
Date	
Relationship to Patient (if signed by a legal representative)	

CONSENT TO VERBALLY DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS, FRIENDS, OR OTHERS

You have the right to identify family, friends, or others involved in your care to verbally receive medical or payment information about you, to help you manage your health care. You may make changes to this list at any time by submitting a new form. Avance Care will only share your health information with the individuals you designate, except as required by law. This consent form does NOT authorize releasing copies of your patient health records, which requires an **Authorization for Release of Medical Records Form**.

[ ] I decline the verbal disclosure of my health information to any parties. I understand that this declination can be revoked at any time by completing and submitting a new form.

I, the undersigned patient or patient's legal representative, consent for Avance Care to verbally disclose the information I have specified below with the following family, friends, or other individuals (as specified below) pursuant to a request from the undersigned patient or legal representative:

Name	Relationship	Phone Number

1. Type of information to be verbally disclosed: (Check all boxes that apply)

[ ] ALL information (including billing information, information related to behavioral or mental health services including psychiatric consults, development disabilities, HIV/AIDS and test results, sexually transmitted diseases, hepatitis, tuberculosis, and social service needs), *excluding substance use disorder information*, as protected under 42 CFR Part 2.

[ ] Health Plan information ONLY (billing, benefits, payments authorizations) including updating demographic and other information

[ ] Other (describe): _____

[ ] **However, I specifically withhold disclosure of the following types of information (patient to fill in examples of information to be withheld from the designated individuals)**

_____

I understand that this authorization is voluntary and that I have the right to revoke it at any time, except where the organization has already made disclosures based on this consent. This authorization will remain in effect for two years from the date of signing and will need to be renewed thereafter. If a new Consent to Verbally Disclose Protected Information to Family Members, Friends, or Others form is received with updated permissions for the same family member, friend, or other person, the new version will automatically revoke the previous one on file. If this consent is signed by a minor, it will automatically expire when the minor reaches the age of 18 years old.

_____ _____

Signature of Patient/Authorized Individual Date

_____ _____

Patient Name Date of Birth

If signed by a personal representative of the patient, please print name below and indicate relationship to the patient. For Legal Guardian or Power of Attorney, please submit Legal Documentation with this form.

_____ _____

Print Authorized Representative Name Relationship to Patient

CONSENT TO VERBALLY DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS AND FRIENDS

INFORMATION SHEET

We have established a process that allows you to tell us who we may talk with about your health care. This generally includes appointments and scheduling information, lab and test results, treatment information, and billing information. Please note that by completing this form, you are not granting the individuals listed any authority to make medical decisions on your behalf. This form is solely for the purpose of identifying individuals who may receive information, but it does not authorize them to participate in medical decision-making.

How can I give others permission to get verbal information about me?
Complete the Consent to Verbally Disclose Protected Health Information to Family Members, Friends, or Others form to let us know to whom we may speak about your information. Check the appropriate boxes to indicate what information we may discuss.

How is the information on the form used?
Anytime your designated person(s) call or makes a request on your behalf, we will verify the individual has your permission to receive the information and then we will share the information.

What are some examples of when this form might be useful?

- If an individual wants to share information with a spouse or significant other
- If an elderly parent wants an adult child to help understand medical treatment instructions
- If an adult child is helping with billing questions
- If a friend is helping a patient with health issues
- If a college student wants information shared with a parent
- If an adult child calls to speak with their parent's provider regarding their medical treatment

Does this mean that you will not speak to anyone I haven't specifically named on this form?
No. If permitted by law, Avance Care may speak to other individuals involved in your care (or payment for that care).

What if I change my mind?
Please complete the **REVOCATION TO CONSENT TO VERBALLY DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS, FRIENDS, or OTHERS** form.

Forms are available at your clinic, or you can obtain a new form at www.avancecare.com. (Note: If an updated Consent to Verbally Disclose Protect Information to Family Members, Friends, or Others form is received and it has an identical family member, friend, or other person listed with updated permissions (different checkboxes), the new version will automatically revoke the previous version on file.)

What happens if I don't complete the Consent to Verbally Disclose Protected Health Information to Family Members, Friends, or Others Form?
We will continue to protect your health information as required by law.

Can the person(s) I designate also get copies of my medical records?
No, they can only receive verbal information. To get copies of medical records, complete a separate **Authorization for Release of Medical Records Form** available at your clinic or at www.avancecare.com.

Avance Care – Pediatric Medical History

Today's Date:		To help us meet your healthcare needs, please fill out all items.

PATIENT INFORMATION

Patient Name: (First) (Middle) (Last)	Date of Birth (mm/dd/yyyy):	Gender: ○ Male ○ Female ○ Transgender

Please list any current medications, herbal supplements or vitamins your child is taking. Please include dosages and how often the patient takes them.
○ None

List any allergies: (foods, drugs, environment, immunizations) **and reaction patient had** when they were exposed:
○ None known

PAST MEDICAL HISTORY

Please list all serious illnesses, medical problems, accidents, and injuries with dates:
○ None

Please list any hospitalizations in the past (admitted into the hospital):
○ None

Describe all operations, surgeries, or medical procedures (include dates):
○ None

FAMILY HISTORY

Do any siblings, parents, grandparents or children have any of the following (please answer all questions):

	Yes	No		Yes	No		Yes	No		Yes	No
Diabetes	○	○	Stroke	○	○	Drug/Alcohol Abuse	○	○	Sleep apnea	○	○
High blood pressure	○	○	Asthma	○	○	Depression/Anxiety	○	○	Blood clots	○	○
High cholesterol	○	○	Eczema/Dry Skin	○	○	Other Mental Illness	○	○	Bleeding disorder	○	○
Heart attack	○	○	COPD/Emphysema	○	○	Seizures	○	○	Kidney disease	○	○
Heart disease	○	○	Tuberculosis contact	○	○	Obesity	○	○	Cancer	○	○

If you answered yes to any of the above, please specify the family member (for example, maternal or paternal grandparent):

_____

SOCIAL / SAFETY

Does the patient always use a car seat/seat belt when riding in a car? ○Yes ○ No

Are there any smokers who live in the house? ○ Yes ○ No

Does your child always wear a helmet when riding a bicycle, scooter, skateboard, rollerblading, or skating? ○ Yes ○ No

Are there any weapons in the house? ○ Yes ○ No If yes, are they secured and locked away? ○ Yes ○ No

Do you consider Avance Care your Primary Care Provider? ○ Yes ○ No If no, please provide the name:

_____

Would you like us to fax your visit notes to the Provider? ○ Yes ○ No If yes, please provide the fax number:

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the doctor's office of any change in my child's medical status.

Signature of Parent or Legal Guardian:	Date Completed:

Insurance Coverage of Physical Exams (Preventive Services)

A Comprehensive Physical Exam, also known as a CPE, is a series of routine medical tests/exams that your healthcare provider performs to check your overall health. This notice pertains to the components of a physical examination (preventive services) that are and are not typically covered by Medical Health Plan coverage.

Physical Examination Components typically covered by Insurance plans:

- Review of Medical History
- An individualized review of medical risk factors
- Height, weight, blood pressure, BMI calculation
- For male, clinical testicular examination, and self-exam instruction
- For female, Pelvic Exam, Pap Collection, and Breast Exam with self-exam instruction
- Skin examination and counseling on skin cancer prevention
- General Assessment Screening, Vision and Hearing Screening
- Review and explanation of lab results, if applicable
- Screenings for common or preventable diseases. For example, screening for high blood pressure, obesity, high cholesterol, diabetes, and certain forms of cancer.
- Complete physical examination
- Review of immunization history and administration of any if necessary.
- Counseling on healthy living choices, normal development and recommendations for proper diet and exercise.

Laboratory Test(s), Screening Test(s) or Diagnostic Test(s) may be ordered by your healthcare provider, to further evaluate and treat conditions. Please note, the below services may or not be covered at 100%, this will be determined once your claim is submitted and processed by your insurance carrier. Depending on if the service is screening or diagnostic, the below services may or may not be subject to a co-payment, co-insurance and or deductible.

- Bone Density Testing (Osteoporosis)
- Mammogram
- Colonoscopy
- Prostate Test (blood lab test)
- Diagnostic Pap Smears
- Diabetes Screen (blood lab test)
- Cholesterol Screen (blood lab test), etc.

Services that are not normally covered by insurance plans during a physical examination:

- Evaluation and management of specific acute problems or illness. For example, a discussion of a recent cough, sore throat, pain, or injury.
- Procedures such as mole removal, joint injections, and skin biopsies.
- Medication Management – Prescription Refills
- Chronic Care Management services

Laboratory testing is processed through our partner vendor, LabCorp. You may see their name on your EBO, or you may receive a bill from them for items not covered by your insurance plan. Please contact LabCorp directly with any questions pertaining to these items.

Vaccine administration is processed through our partner vendor, VaxCare. Any vaccine-related claim filing will show on your EBO under their organization name. You may receive a bill for any items not covered by your insurance. Please contact VaxCare directly with any questions pertaining to these items.

If you have additional health concerns outside of those normally covered by your medical health plan for a Comprehensive Exam, please speak to a staff member and/or Provider at the clinic. Additional health concerns may be able to be discussed during your preventive exam; however, there will be additional charge for an office visit at the time of service (co-pay, deductible, or co-insurance), or you may be instructed to schedule a separate appointment to discuss those concerns.

If your healthcare Provider finds any abnormal finding(s) during your “covered” Physical Exam, your healthcare provider will address the finding with you and document it/them in your medical record. Your healthcare provider can bill this abnormal finding as a separate Office Visit along with your Physical Exam to your insurance company. Please note, you (the patient) will be responsible for any co-pay, deductible, or co-insurance pertaining to the Office Visit, this payment should be paid at the time of service.

I have read the above patient notice and acknowledge the content of this notice by signing below.

_____ _____
Signature of Patient/Authorized Representative Date

_____ _____
Patient Name Date of Birth

If signed by a personal representative of the patient, please print name below and indicate relationship to the patient. For Legal Guadian or Power of Attorney, please submit Legal Documentation with this form.

_____ _____
Print Authorized Representative Name Relationship to Patient