

# FamilyCare HealthCenter

<b>Patient Name:</b>	<b>Birthdate:</b>
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## PERMISSION TO TREAT AND BILL FOR SERVICES

**Permission for Treatment and Examination:** I hereby agree to examination and/or treatment as Physicians, Physician Assistants, Dentists, Nurse Practitioners and/or Certified Nurse Midwives of FamilyCare feel necessary. I agree to lab work recommended including drug screens that will be discussed before being ordered.

**Permission to release medical records:** FamilyCare can release any and/or all of my records, or other information needed, to my insurance company and its representative or any others to which I have requested FamilyCare to submit charges.

**Responsibility for Care:** I accept full responsibility for all the health services provided by FamilyCare.

**Billing and Payment:** I give FamilyCare permission to bill and receive payment directly from any insurance company or third party payer for services provided to me.

**Responsible Party:** If this form is signed by a responsible party for a patient, that party assumes full financial responsibility and liability.

**I understand and agree to these terms.**

\_\_\_\_\_  
Date **X Signature ( ) Patient ( ) Parent ( ) Guardian ( ) Other**

\_\_\_\_\_  
Print Name of Responsible Party (if not patient)

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (NEW PATIENT ONLY)

I certify that I have been given a copy of FamilyCare's Notice of Privacy Practices. The notice of Privacy Practices explains how my information may be used and shared for my treatment and other services for other purposes that are permitted or required by law.

I understand that FamilyCare may change the privacy practices. I can request a revised Notice of Privacy Practices at any time.

\_\_\_\_\_  
Date **X Signature ( ) Patient ( ) Parent ( ) Guardian ( ) Other**

\_\_\_\_\_  
Print Name of Responsible Party (if not patient)