Family Care Center

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

Please initial to the right of each statement acknowledging your understanding

I acknowledge that I have received or have been offered the notice of Privacy Practices **Int**____
from Family Care Center.

I acknowledge that I have read, understand, and received a copy of the financial policy. **Int**____
I further understand that part of the financial policy includes policies relating to unpaid copayments, "no showed" and "late cancel" appointments. I understand that Family Care Center expects full payment, within 30 days, from me on patient balances after my insurance is billed and responds to my claim. If I am self pay (no insurance), I understand that I am expected to pay my charges in full on the date the services are provided to me.

I give permission to Family Care Center Employees to release any medical or demographic Information to the following entities:

Spouse _____ Employer_____ Other_____

Int____

Does your insurance company require that you use a specific laboratory? ___Yes ___No
If yes, please provide us with the name of the laboratory that we need to send your labs to:_____
_____

Patient Consent

I authorize the providers at Family Care Center to provide medical treatment to me or my minor child. This authorization is valid for one year from the date of signing. **Int**____

Signature of Patient (parent or legal guardian)_____

Date_____ (expires one year from this date)