Plumtree Family Health Center

Patient Name: ______________________________________Date of Birth: _________________

FINANCIAL AGREEMENT

I acknowledge and agree that co-payments are due at the time of treatment. I acknowledge that I need to bring my insurance card for every visit. I accept full financial responsibility for all charges for services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges. Plumtree Family Health Center, LLC reserves the right to review, change and/or modify the terms of the financial policy at its discretion.

Please acknowledge receipt and review of this notice by signing initials. **X** __________

INSURANCE ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s) have insurance coverage and assign directly to Plumtree Family Health Center, LLC all insurance benefits, if any, otherwise payable to me for services rendered by these physicians in person or under their supervision. I understand that I am financially responsible for all charges whether or not paid by insurance. It is the patient's responsibility to question their insurance carrier regarding benefits and coverage or lack thereof for specific services. Plumtree Family Health Center, LLC may use my health care information and may disclose such information to my insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. A photocopy of these assignments shall be valid as the original.

Please acknowledge receipt and review of this section by signing initials. **X** __________

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE TO PATIENTS

Plumtree Family Center, LLC is required by law to maintain the privacy of protected health information, and to provide patients with this notice of its duties and practices as well as changes to those practices. The Privacy Notice to Patients describes how medical information about you may be used and disclosed and how you can get access to this information. I understand that I have the right to refuse to sign this acknowledgement and that I have the right to revoke, in writing, and consent that I provide for access to my and/or my minor/child's record or to the patient for whom I have legal responsibility of.

Also, we have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

Please acknowledge receipt and review of this section by signing initials. **X** __________

CONSENT FOR TREATMENT

I AUTHORIZE Plumtree Family Health Center, LLC to provide me with medical care and treatment.

Please acknowledge receipt and review of this section by signing initials. **X** __________

By Signing below I have read and agree to the term of this entire agreement.

Patient Signature\Guardian: ____

Relationship to Patient: ____

Date: ____________________

PDF created with pdfFactory trial version www.pdffactory.com