First Medical Care

Treatment and Payment Information

I hereby authorize the following:

1. I authorize examination and treatment by the healthcare providers with First Medical Care, Inc. (including Physicians, Nurse Practitioners, and Physician Assistants).
2. I authorize First Medical Care, Inc. to obtain records from other sources as may be necessary for the diagnosis and treatment.
3. I authorize to release any medical information necessary to process insurance billings.
4. I authorize payments of insurance benefits otherwise due to me to be paid directly to First Medical Care, Inc.
5. I authorize assignment of insurance benefits to First Medical Care, Inc.
6. I shall be personally responsible for supplying accurate and current insurance information and am financially responsible for all claims denied because of missing or inaccurate insurance information.
7. I fully understand that I am financially responsible for all charges and deductibles not covered by insurance.
8. I fully understand I am financially responsible for all unpaid claims secondary to lack of prior authorization from PCP or other healthcare provider.
9. I fully understand that insurance does not cover everything, and I may held financially responsible for services rendered by a Nurse Practitioner.

Patient Name: _____ Signature: _____

Relation to Patient (if signing for Patient): _____ Date:_____