

# PrimeCare

## PAYMENT POLICY – INSURANCE AGREEMENT

I understand that I will be financially responsible for all services received.

I agree to pay any amount not covered by my insurance.

I understand that PrimeCare accepts no responsibility regarding what the insurance company will or will not pay.

I authorize and assign payment of all benefits directly to PrimeCare.

I understand that if my patient balance from PrimeCare goes to a collection agency or an attorney for collection, PrimeCare may elect to assess a fee up to the maximum allowed by law.

I authorize the release of any information to my insurance company that they may need in order to process my claims.

## AUTHORIZATION TO RELEASE INFORMATION FROM PRIMECARE TO ANOTHER PHYSICIAN

I understand that there may be times that PrimeCare may need to refer me to another physician/provider for further medical care. I authorize PrimeCare to release the medical records and/or information needed to the provider to whom I have been referred.

## POLICY ON CONFIDENTIALITY AND PRIVACY

I have read (or been given the opportunity to read) PrimeCare's Policy on Confidentiality and Privacy (the blue laminated sheet) and understand its contents. I understand that PrimeCare makes every effort possible to follow the HIPAA laws regarding my privacy. In keeping with the law, I agree to the following:

I give my permission for PrimeCare to leave a phone message for me:   Yes       No  
I give my permission for PrimeCare to contact me by E-Mail:       Yes       No

I give my permission for PrimeCare to discuss any treatment, payment, or other health related issues with and/or in the presence of the following person(s):

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

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I have read and agree to the above policies set by PrimeCare. I understand that this authorization will remain in effect unless terminated in writing by PrimeCare or myself.

Name(print) \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Witness: \_\_\_\_\_