PATIENT REGISTRATION ACKNOWLEDGEMENTS

- I have read and understand the HIPAA/Privacy Policy/Notice of Privacy Practices for FAMILY MEDICINE OF MT. PLEASANT, P.C.
- I hereby assign my insurance benefits to be paid directly to the healthcare provider.
- I authorize FAMILY MEDICINE OF MT. PLEASANT, P.C. to release medical information required to process my claim and secure payment.
- I have read and understand the Financial Policy for FAMILY MEDICINE OF MT. PLEASANT, P.C.
- I authorize FAMILY MEDICINE OF MT. PLEASANT, P.C. to obtain/have access to my medication history.
- I authorize my provider's office to contact me by mobile phone/email/portal account.
- I understand that I am responsible for knowing the policy provisions and rules of my insurance coverage(s).
- I understand that I am financially responsible for any amount not covered by my insurance including, but not limited to, co-pays, co-insurances, deductibles, and non-covered services.
- I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to FMMP.
- I understand that if I do not have valid medical, I am financially responsible for all fees for provision of medical services, unless other arrangements have been made in advance, payment of these fees is expected in full at the time services are rendered.
- I understand that if I do not provide FMMP with my most recent payer coverage, any services received that are not covered by my insurance, will be my responsibility.
- I understand that my insurance may not pay for the service(s), or procedure(s) provided. Insurance policies have limits to their coverage, and these limits do not always follow the medical indications or preventative care recommended by your physician. Payment for this service/procedure will be my responsibility. *(Motor Vehicle Claims will be billed directly to patients' insurance. A copy of my itemized charges is available upon request. Work Comp Claims will be billed directly to my employer's liability carrier, if reimbursement is not received in a timely manner, I will be responsible for all charges arising from these services.)*
- I understand that failure to remit payment for any amounts deemed patient responsibility may result in my account being referred for collection activity and that I will be financially responsible for any additional fees incurred as a result.
- I understand that any appointments missed, and not cancelled within twenty-four (24) hours, may result in my being charged a Missed Appointment Fee. A copy of the Cancellation/No Show policy is available upon request.
- I accept being asked the Health Assessment Questions and understand that my insurance *will* be billed and that they may or may not cover this expense.
- I understand that if I am here for an annual or preventative examination, and an illness, abnormality or pre-existing problem is addressed during your visit, a medical code for that concern may be added to the visit. This means there may be an additional charge on your bill. We must do this to comply with federal rules.
- I accept Chronic Care Management and Remote Patient Monitoring upon eligibility. I may be responsible for any deductible and/or copay.
- I understand that I will be charged for any check returned by my bank for any reason.
- This acknowledgement will remain in effect until revoked by me in writing and is required to be signed annually. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary to secure the payment.
- A copy is available upon request.

Patient Signature: _____ Date: _____

(Required if electronic signature is not on file)