Rochester Family Medicine PC Privacy and Billing Procedures
Authorization and Acknowledgement

These authorizations/acknowledgements cover all services rendered to me, or the patient I am signing for, today and all future dates of service. I understand I may revoke this authorization by informing Rochester Family Medicine PC in writing, but if I do revoke this authorization, it will not affect anything prior to the date the revocation is received by Rochester Family Medicine PC.

Acknowledgement of Receipt of Notice of Privacy Practices
Authorization to Release Information to Family/Friends or Others

I have received a copy of Rochester Family Medicine PC's Notice of Privacy Practices. I authorize Rochester Family Medicine PC to release any information regarding my treatment; including lab results, x-rays, and medical records, to the following individuals/entities (Rochester Family Medicine PC may not release information or records to the names individuals/entities unless you identify them here):

Name ____ Relationship to Patient ______________________________________

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Name ____ Relationship to Patient ______________________________________

Rochester Family Medicine PC will use my home phone number and primary address supplied during registration to contact me regarding my treatment; including lab results, x-rays, and medical records. I will ensure this information is up to date at every visit.

Authorization to Treat and Bill

I consent to be treated by Rochester Family Medicine PC. If I am not the patient being treated today, I am authorized to consent to treatment and billing for the patient identified below. I authorize Rochester Family Medicine PC to bill my medical insurance for the care I receive today and to release any information the insurance carrier requires to process this bill. I authorize payment of medical benefits to Rochester Family Medicine PC, or to outside labs as described below, for all services performed and billed by Rochester Family Medicine PC. I understand that I am responsible for all charges for the treatment I receive at Rochester Family Medicine PC today. I understand that Rochester Family Medicine PC providers may utilize the Prescription Monitoring Program service at no additional charge to me.

As a courtesy, Rochester Family Medicine PC will bill my medical insurance. If I do not provide complete and accurate insurance information to Rochester Family Medicine PC, I understand Rochester Family Medicine PC may not receive payment for my carrier and I will be entirely responsible for my bill. Even after my medical insurance company pays Rochester Family Medicine PC's bill, I may owe Rochester Family Medicine PC payment for services not covered by my insurance and I agree to pay these promptly to Rochester Family Medicine PC. I understand that Rochester Family Medicine PC may send lab specimens to an outside laboratory. I authorize any lab performing services for me to bill my medical insurance for their services. I understand that my medical insurance may not pay for all services provided by the lab and I agree to pay any remaining balance promptly to any outside lab providing services to me. I understand that Rochester Family Medicine PC is not responsible for payment to outside labs for tests provided to me.

To protect my privacy and prevent fraud, I understand that if I cannot provide acceptable photo identification at the time of service, Rochester Family Medicine PC may choose not to bill insurance and may decline credit/debit cards and checks as a form of payment. I understand that if I fail to pay Rochester Family Medicine PC for services provided to me, the balance owed may be sent to collection and I may incur collection fees of up to 25% in addition to the amount owed for services/treatment rendered. I understand that I may contact Rochester Family Medicine PC to work out payment arrangements that may prevent this additional cost.

Signature ____ Today's Date ____

Patient Name _______________________________________ Patient's Date of Birth ___________________________________

Name of Patient Representative _______________________________ * Relationship to Patient* _____________________________

*(Required if the patient is a minor or if the patient is unable to sign this form.)