Release of Records and Benefits Assignment Authorization:

I hereby authorize France Avenue Family Physicians to furnish information concerning my illness and treatments to Insurance Carriers and Physicians directly involved in my care. I authorize payment of any medical benefits to France Avenue Family Physicians. I certify that the above information is correct and that I am responsible for payment of services rendered. I permit a copy of this authorization to be used in place of the original. My insurer may share past, current and future health and account records with France Avenue Family Physicians about services I've received from France Avenue Family Physicians and other care providers unrelated to France Avenue Family Physicians. These records may be used by France Avenue Family Physicians as needed to manage or coordinate my care and to improve the quality of that care. If I do not agree to this, I will initial below.

_____ My insurer may not release any of my identifiable health records from providers unrelated to France Avenue Family Physicians for the purposes described above.

Medicare Authorization (Medicare or Advantage Insured Patients):

I request that payment of authorized medical benefits be made on my behalf to France Avenue Family Physicians for services furnished me by this clinic. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Yes No Credit and Billing Policy:

I acknowledge that I have received a copy and/or have been made aware of France Avenue Family Physicians' credit and billing policy, which are posted in the reception area. If I would like a copy of the credit policy, I will ask the reception staff.

Yes No Consent for Treatment:

By signing this form, I consent to and authorize my health care providers to examine and treat me. I understand that this could include lab tests, education, or other diagnostic procedures. I understand that my provider is available to explain the purpose of the procedures and treatment, and that I have the right to refuse the recommended treatment.

Yes No Patients Right to Privacy:

I acknowledge that I have received a copy and/or have been made aware of France Avenue Family Physicians' privacy practices, which are posted in the reception area. If I would like a copy of the HIPAA notice, I will ask the reception staff.

Yes No I hereby authorize France Avenue Family Physicians to verbally communicate regarding my care with:

Family member/Caregiver_____

(Name) (Relationship)

Yes No I authorize the staff at France Avenue Family Physicians to leave messages on my phone numbers that are listed in my file.

Patient Signature _____ Date_____

If this visit is the result of a Work Comp Injury or Auto Accident, please notify the front desk staff.