Patient Name:_______________________________________Date of Birth:________/________/________

Assignment of Benefit Agreement

I hereby authorize my insurance company, including Medicare if I am a Medicare beneficiary, to make payments to Port City Urgent Care and Family Practice for medical or surgical services or items rendered to me or my dependent by Port City Urgent Care and Family Practice. Should my insurance carrier or employer deny Port City Urgent Care and Family Practice payment, I understand that I am financially responsible for the charges. I am aware that any unpaid balances will be sent to collections and will incur an additional 30% fee. If sent to collections, I authorize the company to contact me by electronic messaging, mail or phone. I authorize Port City Urgent Care and Family Practice to release any and all of my records to my insurer, or any other third party payer, legally responsible for the payment of medical expenses. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update any and all personal, insurance, and health information.

Authorization for Medical Treatment

I give my consent to Port City Urgent Care and Family Practice, its physicians, physician assistants, healthcare professionals, nurses, and other personnel to provide treatment for me or my dependent.

Release of Information

I permit Port City Urgent Care and Family Practice, its physicians, physician assistants, healthcare professionals, nurses, and other personnel to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care.

Name:_________________________ Phone#:(_______)_______-_________Relationship___________

Name:_________________________ Phone#:(_______)_______-_________Relationship___________

Receipt of Notice of Privacy Practices Written Acknowledgment

A copy (located at check-in window by poster or you may request a hard copy) of the Notice of Privacy Practices from Port City Urgent Care and Family Practice has been made available to me.

I accept the assignment of benefits, authorization for medical treatment, the release of information, and that I have received the Notice of Privacy Practices:

Signature of Patient:____Date:________________

(Signature of Parent/Guardian if under 18)

Witness (Employee)____Date:________________