Family Practice Doctors

CONSENT TO TREATMENT AND ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY FORM

Welcome to Family Practice Doctors, P.A., and thank you for choosing us as your family health care provider. We are pleased to offer you with the highest quality healthcare, integrating the most up-to-date treatment modalities and technology with a family-centered approach.

Consent for Treatment

I consent to the medical care necessary to treat the condition that I seek care for today at Family Practice Doctors including diagnostic test and procedures ordered by Family Practice Doctors' health care providers which may include a licensed Board Certified Family practice physician, License advance nurse practitioner or a licensed physician assistant acting within the scope of practice permitted by state law.

Financial Responsibility

I understand that payment is required at the time of service. As a courtesy to our patients, we will file claims for you with the many health plans that Family Practice Doctors P.A. participates with. Please note that insurance verification or prior authorization is not a guarantee of payment. If for any reason we are unable to verify insurance eligibility prior to office visit or if insurance does not provide coverage or fails to pay the treatment amount in full, that I, the patient is responsible for full payment upon service being rendered. Please note that an estimated patient payment liability is expected at the time services are rendered and this is estimated based on known deductibles, copays, and coinsurance due for your visit. While we may estimate the financial responsibility, it is ultimately the insurance company that makes the final determination regarding eligibility and benefits. Please note that not all procedures may be covered by your insurance company, or may be considered "not medically necessary or cosmetic: by your health plan. Family Practice Doctors will provide patient care based on medical needs and not on patient's insurance coverage. Please contact our billing department if you should have any questions or concerns regarding your billing statement.

Authorization and Acknowledgement

I hereby authorize Family Practice Doctors P.A. and/or its affiliates or other providers to release information obtained during my treatment to my insurance company, third party payers, my employer-based health plans as necessary to file claims on my behalf for services rendered, or for quality assurance, complaints/grievances.

I acknowledge only one consent form for treatment and financial responsibility will be required from my first visit and will be effective from that date for as long as I am a patient in this medical practice.

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Patient Name Printed — Date of Birth

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Name of Patient's Representative, — Relationship
if patient unable to sign due to age/or disability

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Signature of Patient or Patient Rep — Today's Date

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Notice of Privacy Practice Received