PRIMARY MEDICINE, LLC

Patient Name: _____ DOB: _____

Statement of Patient Financial Responsibility

Primary Medicine appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/ co-insurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. Many Insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If you Ins. Carrier deny any part of your claim, or, if you or your physician elects to continue past your approval period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Primary Medicine, for providing rehabilitative services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Primary Medicine, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made to my insurance carrier.

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Consent for Treatment and Authorization to Release Information

I hereby authorize Primary Medicine through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Primary Medicine, to release to appropriate agencies, any information acquired in the course of my or the above named patients' examination and treatment.

Cancellation/ No show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call us 24-hours in advance to cancel your appointment or there will be an additional fee assessed of $25.00. I understand if I do not show for three appointments, I may be discharged from care. You will be notified in writing, via certified mail, if you are discharged from care.

Patient Signature _____ Date_____