

Primary Health Group Chippenham

PATIENT NAME _____ DATE OF BIRTH _____

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

1. _____ (Patient or Guardian Initials)

Financial Agreement.

- I acknowledge, that as a courtesy, Primary Health Group Chippenham may bill my insurance company for services provided to me.
I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
I understand that there is a fee for returned checks.

2. _____ (Patient or Guardian Initials)

Third Party Collection. I acknowledge that Primary Health Group Chippenham may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. _____ (Patient or Guardian Initials)

Assignment of Benefits. I hereby assign to Primary Health Group Chippenham any insurance or other third-party benefits available for health care services provided to me. I understand Primary Health Group Chippenham has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Primary Health Group Chippenham, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. _____ (Patient or Guardian Initials)

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Primary Health Group Chippenham by the Medicare or Medicaid program.

5. _____ (Patient or Guardian Initials)

Consent to Telephone Calls for Financial Communications. I agree that, in order for Primary Health Group Chippenham, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Primary Health Group Chippenham or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or Primary Health Group Chippenham from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. _____ (Patient or Guardian Initials)

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X _____ Date _____

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

- Spouse
Parent
Legal Guardian
Guarantor
Healthcare Power of Attorney
Other (please specify) _____