Advanced Medical Center

PLEASE PRINT

REGISTRATION FORM

Today's Date: Physician (PCP):

PATIENT INFORMATION

Legal Name Last: First: Middle:

Date of Birth: | Sex: ☐F ☐M | Nickname/Goes By:

Billing Address: Apt # | City: | State, Zip:

Secondary Address: Apt # | City: | State, Zip:

GOVERNMENT MANDATED INFORMATION

Language: ☐English ☐Spanish ☐Other____________________ | Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Hispanic/Latino ☐Native Hawaiian/Other Pacific Islander ☐White

Contact Preference: ☐Cell Phone ☐Home Phone ☐Email | Email:

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widow | Student Status: ☐Full Time ☐Part Time ☐Not A Student

Home Phone No.:	Daytime Phone No.:	Cell Phone No.:
( )	( )	( )

Employment: ☐FT ☐PT ☐Retired ☐Self Employed ☐Not Employed | Employer:

GUARANTOR INFORMATION (Must complete Parent/Legal Guardian Form if Patient Under Age 18)

Person Responsible for Bill: ☐Self ☐Other | Address (*if differs from above*): | Home Phone No: ( )

Specify Other:

INSURANCE INFORMAITON

Is this patient covered by insurance? ☐Yes ☐No | Is the policyholder a patient here? ☐Yes ☐No

Insurance Company: | Subscriber Name (If not patient):

Member ID: | Subscriber Date of Birth: | Relationship to Subscriber:

Group Name: | Subscriber Address:

Employer: | City | State | Zip

Secondary Insurance Company: | Subscriber Name (If not patient:

Member ID: | Subscriber Date of Birth: | Relationship to Subscriber:

Group Name: | Subscriber Address:

Employer: | City | State | Zip

PHARMACY INFORMATION (For EHR Entry Only)

Pharmacy Name: | Pharmacy Phone No: ( )

Permission to access Sure Scripts (electronic pharmacy) for the viewing of all Electronically recorded medications: ☐Yes ☐No Please Initial____________

EMERCENCY CONTACT (For EHR Entry Only)

Name of local friend or relative (not living at same address): | Relationship to Patient:

ACKNOWLEDGEMENT OF TRUE AND ACCURATE INFORMATION

The information reported on this document is true to the best of my knowledge. I hereby authorize the physicians and staff of Advanced Family Practice to release any information acquired in the course of my treatment to my insurance company or third party payer as required for claims filed, quality assurance, health plan administration, or complaints/grievances. I understand that the specific information to be released may include HIV virus, Acquired Immune Deficiency Syndrome (AIDS), and mental health. I authorize direct payment to be made to the physicians of Advanced Family Practice for any and all medical or surgical services rendered. I understand that if any services or charges are not covered, or if Advanced Family Practice is unable to verify eligibility, that I am responsible for all charges incurred for services rendered.

Signature ______________________ Date ______________________

Advanced Medical Center

MEDICAL HISTORY

Date: Please provide the following information to your physician.

Education:	Occupation:
Have you ever traveled or lived outside of the US and Canada?	☐Y ☐N Where/When

Please identify any significant medical history for the following family members.

	Alive	Deceased	Present Medical Issues or Cause of Death
FATHER	☐	☐	
MOTHER	☐	☐	
BROTHERS	☐	☐	
SISTERS	☐	☐	
CHILDREN	☐	☐	

Check illnesses that have occurred in any of your blood relatives: ☐DIABETES ☐CANCER ☐BLEEDING TENDENCY ☐KIDNEY DISEASE ☐TB ☐HEART DISEASE ☐STROKE ☐HIGH BLOOD PRESSURE ☐DEPRESSION/ANXIETY ☐ALLERGY OTHER:

Check illnesses or conditions you have had: ☐DIABETES ☐GLAUCOMA ☐HEART DISEASE ☐SEXUALLY TRANSMITTED DISEASE ☐CANCER ☐ASTHMA ☐JAUNDICE ☐BLEEDING TENDENCIES ☐TB ☐PNEUMONIA ☐KIDNEY DISEASE ☐RHEUMATIC FEVER ☐DEPRESSION/ANXIETY ☐STOMACH ULCERS ☐HYPERTENSION OTHER:

List other illnesses not requiring operation for which you were hospitalized:

Previous Operations (Dates, Hospitals, and Name of Surgeon):

Previous colonoscopy ☐Y ☐N If yes, when:

Have you had any serious injuries, broken bones, etc? ☐Y ☐N List:

Have you had allergy or sensitivity to medication or other substances? ☐Y ☐N List:

Do you use tobacco now? ☐Y ☐N Former smoker? ☐Y ☐N	Type and Amount:	How Long?
Do you use alcoholic beverages now? ☐Y ☐N	Daily Amount:	How Long?
Do you drink coffee? ☐Y ☐N	Weekly Amount:	How Long?

List medications used not prescribed to you or recreational drugs, if applicable:

Date of last immunization:

INFLUENZA:		HEPATITIS A:	
TETANUS:		HEPATITIS B:	
PNEUMONIA:		OTHER:	

(For children, please present immunization records.)

Dental (List any problems you have now):

List all current or recently used medications:

Have you had a blood transfusion? ☐Y ☐N Date:

Height Weight How long have you been at this weight?

Your main medical problem and how long have you had it?

What are your main symptoms?

FEMALE QUESTIONNAIRE

Last Menstrual Period:		Last Mammogram:		Last Pap:	

Menes are: ☐Regular ☐Irregular If irregular, please explain

Number of pregnancies: Number of Miscarriages: Number of Abortions:

Oral contraceptives? ☐Y ☐N Other form of contraception:

Any chance you are pregnant? ☐Y ☐N

Xrays and some medications can be harmful to a fetus. For that reason, it is our policy to perform a pregnancy test on all females ages 15-45.

☐ **I agree to a pregnancy test** ☐ **I opt out of a pregnancy test at my own risk**

PHYSICIAN REVIEW

Signature: Date:

MRN: ____________________

CONSENT AND RELEASE FORM

Patient Name (Print): ______________________________ Date of Birth: ______________

CONSENT FOR MEDICAL TREATMENT

I voluntarily present for treatment and consent to my physician and whomever they may designate, associate, treating physician and patient care staff to provide my care. Such care may include, but not limited to, diagnostic procedures, psychotherapeutic treatment, other treatments and medications, pathologic and radiological evaluations and procedures considered advisable in my diagnosis, treatment and course of care.

I acknowledge that no guatantee can be made or has been made as to the results of treatments or examinations at Advanced Urgent Care.

Patient's Printed Name: ____

Patient/Guardian/Guarantor Signature: ____________________________ Date: ____________________

RELEASE AND USE OF PATIENT INFORMATION

In addition to the release and uses of my health information described in the HIPPA Notice of Privacy Practices, I authorize the release of my medical records, information, treatment and advice, and specific health information to:

☐ Check box if you choose the same person as your emergency contact

____
Name Relationship Phone

____
Name Relationship Phone

I understand the information concerning medical care, advice or treatment may include: history, physical, dianosis, laboratory and dianostic testing, specific information concerning alchol abuse, mental health, drug abuse, human immune-deficiency virus, hepatitis, or other infectious diseases.

I understand that I have the right to revoke this authorization at any time

Patient's Printed Name: ____

Patient/Guardian/Guarantor Signature: ____________________________ Date: ____________________

I, hereby, revoke the above Release and Use of Patient Information authorization

Patient's Printed Name: ____

Patient/Guardian/Guarantor Signature: ____________________________ Date: ____________________

Patient Name: ______________________________

Date of Birth: ____________________ Patient Phone Number: ____________________

For Healthcare covering the periods from ______________ to ______________ OR _______ ALL DATES

For the purpose(s) of: ______________________________

I hereby authorize the release of my health records:

TO:	FROM:
Advanced Medical Center 1690 Dunlawton Ave Port Orange, FL 32127 P: (386) 271-2273 F: (386) 271-2274	______________________________ ______________________________ City: ______________ State: _____ Zip: ________ P: ____________________ F: ____________________

☐ I do authorize my records to be faxed ☐ I do **NOT** authorize my records to be faxed

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and substance abuse.

☐ YES, I consent to the release of this information ☐ NO, I do not consent to the release of this information

REVOCATION: I understand that this authorization may be revoked in writing at any time, except the extent that actions have already been taken in response to this authorization for the purposes stated above.

Unless otherwise indicated, this authorization will expire in 90 days from date of signature. The physician and employees are released from any legal responsibility or liability for disclosure to the above information to the extent indicated and authorized herein.

Medical Care is not conditional upon the signing of this authorization.

I understand that there may be a fee for preparing and furnishing this information.

____

Signature of Patient or Legal Representative Relationship to Patient Date

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical records may contain reports, test results and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold **Advanced Medical Center** liable for any misinterpretation of the information in my medical record as result of not consulting my physician for the correct interpretation.

____

Signature of Patient or Legal Representative Relationship to Patient Date

EFFECTIVE DATE: 4/23/2021
HIPAA NOTICE OF PRIVACY PRACTICES

Advanced
Medical Center

THIS NOTICE DESCRIBES HOW MEDICAL INFORAMTION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the Office Manager at: 1690 Dunlawton Ave, Suite 120, Port Orange, Fl 32127

OUR OBLIGATIONS: We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies your ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our Privacy Officer.

For Treatment: We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other professional personnel, including people outside our office, who are involved in your medical care.

For Payment: We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations: We may use and disclose Health Information for health care operations purposes. These uses, and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services: We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in your Care or Payment for Your Care: When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research: Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As required by law, we will disclose Health Information when required to do so by International, federal, state or local law. To avert a serious threat to health or safety, we may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates: We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract

Organ and Tissue Donation: If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation or organs, eyes or tissues to facilitate organ, eye or tissue donation and transportation.

Military and Veterans: If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation: We may release Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes: We may use or disclose your protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release Health Information if asked by a law enforcement official if the information: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime, even if under certain very limited circumstances, we are unable to obtain the persons agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors: We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities: We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose Health Information to authorized federal officials, so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be necessary if: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals involved in your care or payment for your care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your care., if you are unable to agree or object to such disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgement.

Disaster Relief: We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy: You have a right to inspect and copy Health Information that may be used to make decisions about your care of payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make for your request in writing, to "Office Manager" at 1690 Dunlawton Ave, Suite 120 Port Orange, FL 32127. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was note directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records: If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form of format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach: You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Ament: If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to "Office Manager" at 1690 Dunlawton Ave, Suite 120, Port Orange, FL 32127.

Right to an Accounting of Disclosures: You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing to "Office Manager" at 1690 Dunlawton Ave, Suite 120, Port Orange, FL 32127.

Right to Request Restrictions: You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment of your care, like a family member or friend. For example, you may ask that we not share information about a diagnosis or treatment with your spouse. To request a restriction, you much make your request, in writing, to "Office Manager" at 1690 Dunlawton Ave, Suite 120, Port Orange, FL 32127. We are not required to agree to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-Of-Pocket-Payments: If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that (item or service, not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work, to request confidential communications, you must make your request, in writing, to "Office Manager" at 1690 Dunlawton Ave, Suite 120, Port Orange, FL 32127. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are sill entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.advancedurgentcarecenter.com under forms.

Changes to this Notice: We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top left-hand corner.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Office Manager at 1690 Dunlawton Ave, Suite 120, Port Orange, FL 32127. All complaints must be made in writing. You will not be penalized for filing a complaint. For more information on HIPAA privacy requirement, HIPAA electronic transactions and code sets regulations and the proposed HIPAA security rules, please visit ACOG's website, www.acog.org,

Patient/Guarantor Signature ______________________ Date ______________________

Patient Financial Responsibility Statement

Thank you for choosing Urgent Care Center of Port Orange, LLC dba Advanced Urgent Care (AUC) AND Town Center Medical Services, LLC dba Advanced Family Practice; as your healthcare provider. The medical services you seek imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the service you receive. To assist in understanding that financial responsibility, we ask that you read and sign this form. Feel free to ask any questions you have regarding your financial responsibility. If someone else, (parent, spouse, domestic partner, etc.) is financially responsible for your expenses or carries your insurance, please share this statement with them, as it explains our practices regarding insurance billing, copayments, and patient billing. By signing below and/or by receiving medical services from Urgent Care Center of Port Orange, LLC dba Advanced Urgent Care (AUC) AND Town Center Medical Services, LLC (TCM) dba Advanced Family Practice you agree:

1) You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, coinsurance amount or any other patient responsibility indicated by your insurance carrier or services that are not otherwise covered by supplemental insurance.

2) You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply; (A) your health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at TCMS/AUC/AMC, and you have not obtained such authorization or referral; (B) you receive services in excess of such authorization or referral (C) your health plan determines that the services you received at TCMS/AUC are not medically necessary and/or not covered by your insurance plan; (D) your health plan coverage has lapsed or expired at the time you receive services at TCMS/AUC; of (E) you have chosen not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your carrier plan provider directly.

3) You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting verification of current insurance and paying any co-pays or other patient responsibility amount each visit. Your card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be treated as a self-pay patient. As a self-pay patient, our fee is expected to be paid in full at the time of service. If the insurance card or other necessary information is furnished after the visit, we may file a claim with your insurance; and if paid in full by insurance, you will be reimbursed. If you are not prepared to make your co-pay or other patient responsibility amount, your visit may be rescheduled by TCMS/AUC.

4) We may verify your insurance benefits or submit your claim to your insurance carrier as a courtesy to you. You agree to facilitate payment of claims by contacting your insurance carrier when necessary. Without waiving any obligation to pay, you assign to TCMS/AUC, for application onto your bill for services, all of your rights and claims for the medical benefits to which you, or your dependents, are entitled under any federal or state healthcare plan, insurance policy, any managed care arrangement or other similar third-party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to you. You authorize TCMS/AUC and associates, physicians, staff, outpatient clinics and hospitals to release patient information acquired in the course of your examination and/or treatment, including but not limited to, any and all medical records, notes, test results, X-Ray records/reports, MRI Reports or other documents related to your treatment (Including itemization of any charges and payments on my account) that is deemed necessary to process this claim to the necessary insurance companies, third party payors, and/or physicians or health care entities as they require to participate in your care. It is important to notify us as soon as possible of any changes related to your insurance coverage, failing to so do may result in unpaid claims, and you will be responsible for the balance of the claim. TCMS/AUC does not accept responsibility for incorrect information given by you or your insurance carrier regarding your insurance benefits or benefit plans.

5) If your insurance carrier does not remit timely payment on your claim, you will be responsible for payment of the charges within the terms set forth herein. Once your insurance carrier processes your claim, we will bill you for any remaining patient responsibility deemed by your insurance carrier. If any payment is made directly to you for services billed by us, you agree to promptly submit same to TCMS/AUC until your patient account is paid in full. If you make a payment that results in a surplus on your account, you authorize TCMS/AUC to apply the overpayment to any other account for which you are financially responsible, including your account, a member of your family's or dependent's account, or on any account for which your are Financial Responsibility Party, and any remaining balance will be returned to the payor.

6) You will be mailed a billing statement that contains the total cost of your service(s) or procedure(s) received during you visit(s). You may generally expect this billing statement within thirty (30) days after your insurance company has responded to a submitted claim. You must notify us of any errors or obligations to the billing statement within thirty (30) days or they will be deemed accurate, and the fees and expenses shall be deemed reasonable and necessary for the services incurred. If there is an issue with your account, it is your responsibility to contact our Billing Department to address the problem or to discuss a workable solution.

7) Whether or not you have insurance or are self-pay, payment of any account balance is due within thirty (30) days of receipt of your billing statement. If any balance on your account is over one hundred twenty (120) days past due, your account will be in default and auto referred to a collection agency. We may stop sending billing statements any time after the initial statement, but your understand that the amount shall remain due and owing until paid in full.

8) At the time of service, we accept payment by cash, debit card or credit card only. You may submit payment in response to a billing statement via check, debit card, or credit card. If payment is made by check and it is returned or declined for any reason, your account will be charged $35.00 in addition to any costs accrued or charged by any depository institution.

9) Medicare. TCMS/AUC is participating provider with the Medicare program and accepts as payment the Medicare allowable, patient deductible and/or co-insurance. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. You understand that you will be responsible for your annual deductible, the co-payment, and any non-covered services specified by Medicare. We may submit a claim to any supplemental plan as a courtesy to you, so long as you provide all necessary policy information.

10) Motor Vehicle Cases: If you are being treated for injuries related to a Motor Vehicle Accident (MVA), you are responsible for providing the required information necessary to bill your auto insurer. In the event that your claim is denied, you are financially responsible for all charges.

11) Workers' Compensation Cases. Charges for services incurred because of a verified work-related injury will be treated as worker's compensation, and we will bill the workers' compensation carrier as a courtesy. You must provide necessary information to bill the carrier. You are responsible for the completion of information with the employer and approval of the workers' compensation claim. In case your workers' compensation claim is denied, you will also provide us with your medical insurance information. If your claim is denied, we will bill your regular medical insurance carrier. When the claim is no longer pending, and any portion of your claim is ultimately resolved against you by workers' compensation and your medical insurance, you will be required to pay all amounts due within thirty (30) days. If you receive treatment as a result of a third-party liability injury (for example; MVA, premises liability, or other general liability claims against third parties), the balance for services rendered is considered due in full at the time of service. Because Advanced Medical Center (AMC) does not protect charges incurred relating to or arising out of third-party liability, we will not accept a delay in payment due to settlement disputes and/or litigation. We will not accept a letter of protection from an attorney as a guarantee of payment or assignment of third-party insurance payments. AMC cannot act as administrator to resolve financial arrangements. We may agree to bill a third-party insurance company of an at-fault party involved in an accident as a courtesy to you. To bill your claim directly, you must provide is all necessary information to confirm coverage for these payments with the auto/ third-party carrier. We will also collect information about your personal medical insurance in case the auto/third-party carrier denies your claim. Regardless of whether we submit your claim to third-party insurance, as the patient, you are ultimately responsible for payment.

12) Ancillary Services. You may receive ancillary medical services while a patient of TCMS/AUC such as: anesthesia, interpretation of tests, neuropsychological testing, imaging services (i.e. X-rays) and pathology specimen examination. By signing below, you understand that some physicians may not provide services in your presence but are actively involved in the course of diagnosis and treatment. You authorize payment directly for these services under the policy(s) or plan(s) issued to you by your insurance carrier. You may incur additional charges as a result of these ancillary services. You agree to pay all charges due with respect to such services after benefits paid on your behalf by any third-party are credited to your account.

13) Additional Charges. Patients may incur and are responsible for the payment of additional charges at the discretion of TCMS/AUC including but not limited to: (A) charges for returned checks; (B) charges for a missed appointment without 24 hours advanced notice; (C) charges for extensive phone consultations and/or after hours phone calls requiring treatment, or prescriptions; (D) charges for copying and distribution of patient medical records; (E) charges for extensive forms preparation or completion; or (F) any costs associated with collection of patient balances, all as allowed by law.

14) Non-payment on Account. Should collection proceedings to other legal action become necessary to collect an overdue or delinquent account, you understand that AMC has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. You are responsible for all costs of collection including, but not limited to: (A) late fees and charges and interest due as a result of such delinquency; (B) all court costs and fees (but only to the extent allowed by law); and (C) a collection fee to be charged under separate agreement with a third-party collections agency, either as a flat fee or computed as a percentage of the total balance due up to the maximum allowed by applicable law, and to be added to the outstanding balance due and owing at the time of the referral to the third party collection agency. You acknowledge that any such interest assessed on the account will be a late fee as a result of default or delinquency on your account and is not deemed interest as part of a credit transaction. If your account is referred to a collection agency, attorney, court, or the past due status is reported to a credit reporting agency, it may have an adverse effect on your credit history; and related portions of your account, including the fact that your received treatment at our offices, may become a matter of public record. Failure to comply with your financial responsibilities established herein may also result in a Credit Withdrawal of Care.

15) Minor Patients. The parent/guardian of a minor is responsible for payment of the minor's account balance. A minor who is not accompanied by a parent/guardian will be denied any emergency treatment unless charges for the treatment have been pre-authorized. Responsibility for payment of treatment of minor children, whose parents are divorced, rests with both parents. Any court-ordered responsibility judgement must be determined between the individuals involved, without the inclusion of TCMS/AUC.

16) Authorization to Contact. You authorize TCMS/AUC personnel to communicate by mail, answering machine messages, and/or e-mail according to the information provided in your patient registration information. TCMS/AUC, or any agent or servicer of your patient account, may use any information you have provided, including contact information, e-mail addresses, cell phone numbers, and landline numbers, to contact you for purposes related to your account, including debt collection. You authorize TCMS/AUC to use this information in any manner consistent with the information you have provided, including mail, telephone calls, e-mails, or text messages. You expressly consent to any such contact being made by the most efficient technology available, including automatic dialing/e-mailing or similar equipment, or pre-recorded or other messages, even if you are charged for the contact.

17) Financial Responsibility Party. If this or a separate TCMS/AUC Financial Responsibility Statement is signed by another person, on your account, then that co-signature remains in effect until cancelled in writing. Cancellation in writing shall become effective the date after receipt and shall apply only to those services and charges thereafter incurred. By signing as Financial Responsibility Party, you hereby guarantee the full prompt payment to TCMS/AUC of all indebtedness of Patient to TCMS/AUC, whether now existing or hereafter created ('the indebtedness"); and you further agree to pay all expenses, legal or otherwise, incurred by TCMS/AUC in collecting the indebtedness, in enforcing this guaranty or in protecting its rights under this guaranty or any other document evidencing or securing any of the indebtedness. This guaranty shall be a continuing, absolute and unconditional guaranty, and shall remain in force and effect until any and all said indebtedness shall be fully paid. There shall be no obligation on the part of TCMS/AUC at any time to first exhaust its remedies against Patient, any other party, or any other rights before enforcing the obligations of Financial Responsibility Party.

Acknowledgement

By signing below each of the undersigned acknowledges that: (A) I have been provided a copy of the Advanced Medical Center **Patient Financial Responsibility Statement**; (B) I have read, understand, and agree to their provisions and agree to the specified terms; (C) I agree to pay all charges due (or to become due) to AMC for the below Patient's care and treatment, including copayments and deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable; (D) benefits, if any, paid by a third-party will be credited on the Patient account; (E) regardless of my insurance status or absence of insurance, I am ultimately responsible for the balance on the account for any services rendered; (F) If I failed to make any of the payment for which I am responsible in a timely manner, I will be responsible for all costs of collecting the money owed, including court costs, collection agency fees, and attorney's fees (to the extent allowed by law); and (G) failure to pay when due may subject me to late payment charges and can adversely affect my credit report.

I further agree that a photocopy of this Patient Responsibility Financial Statement shall be as valid as the original I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FACSMILE OR ELECTRONIC ('PDF") SIGNATURE, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

Patient/Responsible Party/Guardian   Date   Date of Birth

Patient/Responsible Party/Guardian   Date   Date of Birth

PLEASE READ THE FOLLOWING STATEMENT CAREFULLY

(This section only pertains to those who DO NOT wish the release of patient information in accordance with Section 4 above. By signing below, you are solely responsible for the balance in full at the time of service and no claim will be filed with your insurance plan.)

Waiver of Patients Authorizations

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

Patient/Responsible Party/Guardian   Date   Date of Birth

Patient Acknowledgement
Appointment Cancellation Policy

Patient Print Name: ______________________________ DOB: ________________

A cancellation made with less than a 24 hour notice significantly limits our ability to make the appointment available for another patient in need. Therefore, Town Center Medical Services, LLC dba Advanced Family Practice has instituted an Appointment Cancellation Policy:

Patients are required to provide our office with a 24 hour notice in the event that you need to cancel or reschedule your appointment. This will allow us the opportunity to provide care to another patient. Our office can be reached at 386-481-6690. Please leave a detailed message if an employee is unable to answer your call.

1. A "No-Call", "No-Show" or missed appointment, without proper 24 hour notification, may be assessed with a **$35** fee.

2. This fee is not billable to your insurance.

3. If you are 15 or more minutes late for your appointment, the appointment may be cancelled and rescheduled. The applicable fee may be assessed to the patient.

4. As a courtesy, we make reminder calls, for appointments, one to two days in advance. Please note, if a reminder call or message is not received, the cancellation policy remains in effect.

5. Repeated missed appointments may result in termination of the physician/patient relationship.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

I have read and understand the Appointment Cancellation Policy and I acknowledge its terms. I also understand and agree that such terms may be amended from time-to-time by the clinic

Patient/Guardian/Guarantor Signature: ______________________________

Patient's Printed Name: ______________________________

Date: ______________________________