Prompt Primary Care of Ocala
8750 SW STATE RD 200
Ocala, Florida 34481
(352)861-5444 phone
(352)861-5447 fax

Please print (last name) (first name) (MI)

Do we have your permission to:

Send a recall appointment reminder to your home? Y___ N___

Leave the following information on your home answering machine/voice mail:

Appointment information Y____N____
Billing information Y____N____
Dental/Medical information Y____N____

Leave the following information on your work answering machine/voice mail:

Appointment information Y____N____
Billing information Y____N____
Dental/Medical information Y____N____

I give permission to share *APPOINTMENT AND MEDICAL* information with the person named below: Name:_____.

I give permission to share *APPOINTMENT INFORMATION ONLY* with the person named below: Name:_____.

I give permission to share *MEDICAL INFORMATION ONLY* with the person named below: Name: _____.

AUTHORIZATION AND RELEASE: I understand and agree that insurance policies are an arrangement between an insurance carrier and me. I authorize payment of insurance benefits directly to Prompt Primary Care of Ocala. Furthermore, I understand that Prompt Primary Care of Ocala will try to prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Prompt Primary Care of Ocala will be credited to my account on receipt. I understand and agree to allow this office to use their patient health information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. I understand that I am responsible for all costs of medical care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable upon request. I understand that if Prompt Primary Care of Ocala is not a provider for my insurance company they have the right not to accept assignment or file my insurance. I also understand that if a physician or provider of Prompt Primary Care of Ocala accepts me as a patient, I am consenting to treatment and authorizing them to proceed with any treatment that they feel may be necessary and that I understand that there may be risks and alternatives, the details of which are available upon request.

Patient's Signature_____ Date _____

Guardian's Signature Authorizing Care _____ Date _____