



NORTH PROVIDENCE PRIMARY CARE

I, _____ agree to the following terms:
(Print name of patient)

1. I acknowledge that it is my obligation and responsibility to make my physician's office aware of any changes or lapses in my insurance coverage information. If I am issued a new insurance card which indicates a new policy number or if I change my insurance carrier, I am to report this to my physician's office immediately. Should I fail to provide the information necessary to have my claims properly adjudicated within the filing limits of my insurance carrier, I agree to assure finance responsibility for services rendered to me by my physician.
2. I acknowledge that all copayments are due at the time services are rendered. Payment for non-insured patients are due in full at the time services are rendered.
3. Any patient with past due balances are to pay in full prior to any non-emergent services being rendered.
4. I acknowledge that a \$25 fee will be incurred for any returned checks. I also understand that I will be responsible for paying this whole amount in cash or certified money order or I will be subject to collection procedures.
5. I understand that there will be a \$5 billing fee charged if I do not pay my copayment at the time of service.
6. I acknowledge that any unpaid balances will accrue interest.
7. I acknowledge that not all services provided at North Providence Primary Care are covered by my insurance policy, and I will be financially responsible for such services. I agree to be financially responsible if my insurance carrier denies payment for preventative services.
8. I acknowledge that North Providence Primary Care does not participate with Medicaid, and I will be financially responsible for any services or products not covered by my insurance plan.
9. I hereby authorize direct payment of medical benefits to North Providence Primary Care, Inc. for services rendered in person or under their supervision. I understand that I am financially responsible for any products or services not covered by my insurance plan.
10. I acknowledge that if my account is delinquent, it may be placed with a collection agency or attorney. As such, I will be responsible for all collection fees (33.3% of account total plus expenses) and finance charges of 18% annum.
11. I agree to the following office policy: 24 hour notice is required for cancellation of an appointment. If such cancellation occurs with less than 24 hours notice, a \$25 fee will be incurred which cannot be charged to my insurance carrier.
12. Assignment of insurance benefits: I hereby authorize North Providence Primary Care to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits. A photocopy of these assignments shall be valid as the original.
13. I acknowledge receipt of the Notification of Privacy Practices of North Providence Primary Care.
14. I consent to medical treatment when such care is deemed necessary by my physician. This care may include but not be limited to exam, procedures, and diagnostics. I authorize the physician or any other healthcare providers to order and administer any treatments or procedures or diagnostics which may be deemed necessary or advisable in the diagnosis and treatment of any injury, illness or as a preventative screen.

I have had the opportunity to ask questions regarding the above tenants and understand its content & significance.

Patient Signature: _____ Date: _____

Signature of Authorized Representative/Guardian: _____ Date: _____

1830 MINERAL SPRING AVENUE, PROVIDENCE RI 02904

Phone: (401) 351-1900 • Fax (401) 270-3080