Authorization for Treatment and Financial Agreement

I hereby apply for treatment by **Mid-Atlantic Family Practice's** providers and/or their assistants. Such treatment may include medications, injections, x-rays, and other office procedures as they deem medically necessary.

Further, I authorize the filing of any and all insurance claims in-force, and request direct payment to **Mid-Atlantic Family Practice, LLC** of any amounts due. **I** understand that **I** am financially responsible for all charges not covered by my benefits and accept full responsibility for such charges. Regulations pertaining to medical assignment of benefits apply. I also understand that should my insurance plan require a copay, I am required to pay it on the day of service. Furthermore, if Mid-Atlantic Family Practice does not participate with my insurance plan or I am a self-pay patient, I am required to pay all charges on the day of service.

I further acknowledge that I have been offered a written copy of Mid-Atlantic Family Practice's **Payment Policy** detailing my financial responsibility to Mid-Atlantic Family Practice'

Finally, I permit a copy of this authorization to be used in place of this original.

If I do not sign this consent, or later revoke it, Mid-Atlantic Family Practice may decline to provide treatment to me.

Name/Legal Guardian: ______________________________________ Date: _______________

Signature: _________________________________

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Internal Use Only:

If patient or patient's representative refuses to sign the Authorization for Treatment and Financial Agreement / Acknowledgement of Receipt of Privacy Notice, please document date and time the notice was presented to patient and sign below.

Presented on (date & time): ___________________By (name & title): ____

Revised 07/25/18