Abundant Life Family Medicine

By signing below you verify the above information to be true and correct. You understand that you are responsible for all charges at the time services are rendered unless prior payment arrangements have been made.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by picking up a copy at our front desk or requesting that a copy be mailed to you.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on you prior consent. A photocopy if this signature is as valid as the original.

Your signature below authorizes your insurance company to make payments of medical benefits to Abundant Life Family Medicine on you behalf for medical services rendered, you agree to pay promptly and any balance outstanding after insurance payment or denial of benefits. You understand you are financially responsible for payment of services regardless of insurance status and expected benefits.

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Patient/Guarantor’s Signature Date

Thank you for taking the time to give us this important information and thank you for giving Abundant Life Family Medicine the opportunity to meet your health care needs.

“Abundant Life Family Medicine…helping you live life to the fullest!”