**Patient Consent, Data Sharing, HIPAA & Protected Health Information**

I hereby consent to medical evaluations, testing and/or treatment provided to me by staff at First Care

Medical Centers, LLC (First Care). I understand that First Care participates in health data sharing through

electronic medical records. I understand that I have the right to decline participation at any time with written notice. I understand that First Care may use or disclose any Protected Health Information (PHI) necessary to carry out treatment, payment or healthcare operations. I authorize the release of any information concerning me or my child’s health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I understand that the Notice of Privacy Practices provides information about how my PHI will be used and/or disclosed. I have the right to review the Notice of Privacy Practices before singing this consent, and I have the right to revoke the consent at any time in writing.\* If I revoke consent, First Care may decline to treat me or continue to treat me with limited diagnostic testing; furthermore, First Care would not be permitted to perform x-rays, send out labs, or bill my insurance because my PHI would be required to be released to these agencies for diagnostic and/or payment purposes. I was offered a copy of the First Care health disclosure policy.

**Mobile phone**

I authorize First Care to contact me by mobile phone.

**Financial Policy**

I hereby grant permission to First Care to perform such medical/surgical procedures which are deemed

necessary and understand that all charges are tentative until a final review by billing. I authorize

information and subsequent visits to be relayed both verbally and written via phone, fax, or email to my

family doctor, commercial insurance company, employer, and/or work comp insurance carrier, if

applicable. I understand that whether I am insured or uninsured, I am responsible for any deductibles and

co-pays, or payment in full at the time of service. I understand that if I am a guardian and/or authorized

representative accompanying a minor, I am responsible for payment. I have supplied the particulars of my

insurance coverage and authorize First Care to release any information required for my insurance claim and

authorize my representing insurance carrier to pay any benefits billed for my care directly to First Care. I

understand that First Care does not accept responsibility for collecting an insurance claim and/or negotiating

a disputed claim. Furthermore, if insurance claims are not paid in a timely manner, the balance is my

responsibility.

I have read this policy and understand that, regardless of my insurance coverage, I am responsible for

payment of my account in full within 90 days; furthermore, if I have not paid the balance due and my

account is sent to a collection agency; I understand that I am responsible for any collection fees.

**Credit Card on File**

I agree to allow First Care Medical Centers to charge my credit card (the "Payment Method") for any patient balance due (up to the Maximum Charge Amount indicated), for all services provided by the Practice to the patient(s) listed on the Authorization on or after the Effective Date and before the Expiration Date. I acknowledge that:

* My Payment Method will only be charged for the remaining patient responsibility not paid by insurance, after applicable insurance has been applied.
* I will receive a receipt for each payment detailing the amount charged.
* My Payment Method will be charged for services rendered to the Patient (listed above) and any patient(s) who-at the time their charge drops-have combined billing and statements with the above patient (if this functionality has been enabled with the practice).
* If the eligible charge(s) exceed the Maximum Charge Amount, First Care will bill me directly for any remaining amount beyond the Maximum Charge Amount, and I will be responsible for any such balance.
* My Payment Method information will be securely stored by the Practice and/or the Practice's trusted service providers to facilitate collection of payments.
* I may cancel this Authorization at any time by contacting First Care. If I cancel, the Practice will bill me directly for any patient responsibility, and I will be responsible for any such amounts.
* If I make any changes to this Card on File Authorization (e.g., by contacting the Practice or via online payment workflows powered by athenahealth, Inc.), such changes will supersede the details included in this Authorization and will automatically amend it.
* All information I have provided in connection with this Authorization is true and accurate. I certify that I am an authorized user of the Payment Method

I understand if I choose not to store my credit card on file First Care will collect a $100 deposit for any balance due not covered by insurance i.e... outstanding copays, coinsurance, or deductibles not covered by my insurance company. I understand this deposit will be collected at check-in before services are rendered.

**Medicare**

I understand that First Care providers are not enrolled with Medicare; therefore, are unable to bill Medicare Part B for any services rendered. First Care does have select providers who have opted out of Medicare, which means Medicare patients can sign a contract agreeing to pay in full privately with the understanding Medicare will not be billed by First Care or the patient for **covered services**. I am denying that I have Medicare Part B health insurance coverage or am choosing to see a provider who has opted out of Medicare, and I agree to pay in full for non-covered services rendered.

**Patients Covered by Medicaid Insurance (only)**

I understand that First Care will bill Alaska Medicaid for all Medicaid covered services I receive. If I

receive any services that are non-covered, I will be expected to pay for those services upon checking out.

Any medications dispensed from First Care will need to be paid in full upon checking out. Adults will be

expected to pay a co-pay of $3.00; however, treatment will not be denied if I don’t have my co-pay, and it

will be part of my patient balance. If First Care discovers there is other insurance as primary, and this information was not provided at the time of service I will be financially responsible for the bill.

**Workers’ Compensation Patients (only)**

I, the injured worker, am responsible for reporting my Work Comp injury to my employer within 4 days of the injury. My employer is responsible for reporting the injury to their Work Comp adjuster within 10 days of the injury notification. The Work Comp insurance carrier is responsible for paying First Care within 30 days of receiving the bill. I will be responsible for the balance due for any of the following: if the employer fails to file the report of injury to Work Comp, if Work Comp denies the claim, or if I fail to report the injury to my employer.

**SureScripts**

I, or my authorized representative, request that health information regarding my care and treatment be

released as set forth on this form:

In accordance with Alaska State Law and the Privacy Rule of the Health Insurance Portability and

Accountability Act of 1996 (HIPAA), I understand that:

1. First Care Medical Centers, LLC (First Care) uses SureScripts, Inc., a prescription system that

allows prescriptions and related information to be exchanged between my providers and the

pharmacy. The information sent between these systems may include details of any and all

prescription drugs I am currently taking and/or have taken in the past. This information will be

utilized to First Care.

2. This authorization may include disclosure of prescription information related to alcohol and drug

abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to

First Care.

3. I have the right to revoke this authorization at any time by writing to First Care. I understand that I

may revoke this authorization except to the extent that action has already been taken based on this

authorization.

4. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or

eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be re-disclosed by the recipient, and this redisclosure may no longer be protected by state or federal law.

6. This authorization expires one year from the date of my signature below.

7. THIS AUTHORIZATION DOES NOT AUTHORIZE FIRST CARE TO DISCUSS MY HEALTH

INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED

UNDER APPLICABLE LAW.