Friendship Medical Clinic, LLC.

5482 HWY 15 N ECRU,MS 38841

Office: (662)488-8799 · Fax (662)488-8729

Name: Last_____ **First**_____

Middle Initial :_____ **Address:**_____

Zip: _____ _____

Phone:_____ **Alternate Number:** _____

Date of Birth: ____/_____/_____ **Sex:**_____ **Race:** _____

Pharmacy and Location: _____

Social Security Number: _____

Emergency Contact:

Name:_____**Address:**_____
Relation: _____ **Phone:** _____

Are they allowed to view your medical records? Y N

**If the patient is a minor and is under a parent's or guardian's insurance please provide the following information on the insurance holder:

Name: _____ **Address:** _____

Date Of Birth: ___/___/_____ _____

Place of Employment:_____

Valued Patient:

1. Thank you for choosing us as your health care provider. The following is our financial policy. Our main concern is that you receive the proper and optimal treatment to restore or maintain your health. If you have any questions or concerns about our payment policies, please do not hesitate to ask our financial counselor.
2. We ask that all patients read and sign our Financial Policy prior to receiving services. Payments for non-covered services are due at the time services are rendered.
   Your insurance policy is a contract between you, your employer, and your insurance company.

3. All charges are your responsibility, whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. Fees for these services or co-payments are due at the time of service.
5. If your insurance company does not pay your balance in full within 45 days, we ask that you contact the carrier to help in processing your payment.
6. If your insurance company does not pay within 60 days, we require you to pay the balance due.
7. All checks are processed by Federal Automated Recovery Systems.
8. We will refund any credits on your account to you or your insurance company depending on the circumstance. However, if you have another account balance, any credit will be transferred to the account with the balance.
9. Financial Responsibility
   I/We the undersigned, jointly and severally, in consideration for the services rendered, accept financial responsibility and agree to pay Friendship Medical Clinic, LLC. for its charges for the services rendered to the patient upon receipt of a statement for such charges. The undersigned further agrees that if such indebtedness is placed in the hands of a collector or any attorney for collection, the undersigned will pay reasonable collection fees and attorney fees, interest, court cost and other collection costs and expenses. I further authorize my overpayment due me on this account to be applied to any other outstanding balance that I may owe at Friendship Medical Clinic, LLC..

10. Assignment of Medical Insurance Benefits
    I transfer and assign to Friendship Medical Clinic, LLC. and to any applicable physician all of my rights to benefits payable to me or to a beneficiary. By this assignment, I authorize payment directly to Friendship Medical Clinic, LLC. and directly to the physician. I understand and agree that if any part of my account is not by insurance, for whatever reason, I am still financially responsible for the indebtedness. It is my responsibility to take the action necessary for such benefits to be paid to Friendship Medical Clinic, LLC. or to the physician.

11. Outstanding Indebtedness
    In the event that a charge is outstanding 45 days following date of service, a patient presented to Friendship Medical Clinic, LLC. for treatment will be required to pay and estimated fee up front prior to treatment unless the account is brought up to date at the time of the subsequent visit.

12. Communications Regarding My Account
    Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any servicers and any collectors of my accounts, through various means such as (1) and cell, landline, or text number that I provide, (2) any email address that I provide, (3) auto dialer systems, (4) voicemail messages, and other forms of communication.

We appreciate your trust in us and we honor the opportunity to serve you.

Printed Name X_____

Signature of Responsible Party

X_____

Date X_____

Friendship Medical Clinic will not discuss your personal health information with anyone except those allowed under federal and state law without your authorization. Please list the names, relationships, and phone numbers of those with whom you authorize our staff to discuss your personal information. If you wish for your information to be discussed with anyone other than yourself***, you must list this person(s)*** below.

Name	**Relationship**	**Phone**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*Please note that this only authorizes verbal communication. A written authorization from the patient or authorized personal representative is required to release any information in writing.

**if you wish to add anyone to this list at a later date, please notify the receptionist.

Consent to treat:

I hereby give the staff at Friendship Medical Clinic to right to treat the patient listed below.

Patients Name:_____ DOB:_____

Patients/Guardians Signature:_____ Date:_____

Notice of privacy practice acknowledgement

I acknowledge that I have reviewed a copy of Friendship Medical Clinic's Privacy Policy. I also acknowledge that Friendship Medical Clinic cannot discuss my personal and/or health information with anyone other than those listed above.

Patient/ Guardian Signature:_____

Date:_____