



Robinwood Family Practice – Consent/ Authorizations

Patient Name: «PName» Date of birth: «PDOB»

Please read carefully:

- All charges (e.g. co-pay, deductibles, self-pay, etc.) are due at the time professional services are rendered.
• For those services provided and submitted to my insurance company, I hereby authorize payment of medical benefits to Robinwood Family Practice.
• The patient is responsible for all fees.
• The fee ticket may be used to file insurance claims.
• For minor: I understand that I am fully responsible for this minor’s medical charges and agree to pay all charges for services rendered by Robinwood Family Practice.
• I hereby authorize Robinwood Family Practice to furnish information to any insurance company or authorized agency specified regarding information concerning my medical care.

Consent for Treatment: I authorize providers at Robinwood Family Practice to perform examinations, procedures, laboratory tests and to administer such medications as, in his or her opinion, as necessary for my care.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Ancillary Services: I understand that Hagerstown Medical Lab may be performing laboratory studies as ordered by my physician, and collected at Robinwood Family Practice. These studies will be billed to me by Hagerstown Medical Lab. I understand that my insurance may not cover these services, and that I am fully responsible for these charges.

Release of Information: Often it is difficult to reach a patient to convey physician orders or test results. In this event, with your signed authorization, we would release such information to a person you designate. Please complete the section below.

I authorize Robinwood Family Practice to release any information required in the course of my examination or treatment to the following designated persons:

Name: \_\_\_\_\_ Name: \_\_\_\_\_
Relationship: \_\_\_\_\_ Relationship: \_\_\_\_\_
Phone #: \_\_\_\_\_ Phone #: \_\_\_\_\_
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_