Express Care Clinic/West Lincoln Family Medicine

New Patient Registration

Power of Attorney Held By (If applicable, please provide a copy for your chart.)	
Name	
Address	Phone

Living Will (If applicable, please provide a copy for your chart.)	
Attorney Name	Firm
Address	Phone

Notice of Privacy Practices

I have been offered a copy of Express Care Clinic/West Lincoln Family Medicine's privacy practices.

Signature: Date:

My signature below gives permission for Express Care/West Lincoln Family Medicine to access the electronic prescription history for the patient.

Signature: Date:

Message Authorization

Representatives of Express Care Clinic/West Lincoln Family Medicine are allowed to leave any and all information regarding my status as a patient on my voice mail, answering machine, or email account. I realize this information many include pertinent health status and/or financial information.

Signature: Date:

Express Care Clinic/West Lincoln Family Medicine may communicate information to the following people regarding my health status as needed.

Name:	Phone Number:	Relationship to Patient:
Name:	Phone Number:	Relationship to Patient:

Do **NOT** leave a message (check box if applicable) ☐

Signature: Date:

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me, or, on my behalf, to Express Care Clinic/West Lincoln Family Medicine for any services furnished to me by its physician. I authorize my holder of medical information to be released to the Centers for MEDICAID and MEDICARE services and its agents any information needed to determine these benefits or the benefits payable for related services.

Secondary Insurance Benefits Authorization

I hereby authorize payment of Medigap and /or Secondary insurance benefits to Express Care Clinic/West Lincoln Family Medicine for all claims filed on my behalf. This authorization applies to all services until it is revoked by me or my representative.

Signature: Date:

Payment Authorization

I hereby authorize payment directly to Express Care Clinic/West Lincoln Family Medicine, if any, otherwise payable to me for services performed by the medical clinic not to exceed the reasonable and customary charge for those services. I understand the provider's charge may exceed the private insurance carrier payment, and if greater than such payment, I will be responsible for that amount. This balance may amount to deductible, co-insurance, non-covered services and /or supplies. I understand my co-payment, if any, is due and payable at the time of service and that I may be charged a late fee for the failure to pay at the time of service. I understand there is a $30 return check fee.

Signature: Date:

Release of Information

I hereby authorize Express Care Clinic/West Lincoln Family Medicine to release any information required in the course of my examination or treatment to my insurance and/or other entities for continuity of care.

Signature: Date: