_____ Initial **Arrival Time for New Patients: P**lease arrive 15 minutes prior to your scheduled appointment time. New patients who arrive after their scheduled time will be rescheduled.

_____Initial **Arrival Time for Established Patients**: All patients who arrive 5 minutes or more after their scheduled appointment time will be rescheduled or may wait to see if they can be worked in. Wait times vary and are not a guarantee you will be seen.

______ Initial **ASSIGNMENT OF BENEFITS**: I authorize my insurance company to pay directly to First Choice Primary Care the cost allowable and otherwise payable to me under my insurance policy, applicable to the professional services rendered. I agree to pay all charges not covered by insurance payments or if I receive payment from insurance filed by your company, I will forward the payment to your office within one week of receipt of funds.

_____ Initial CONSENT **FOR TREATMENT**: I authorize First Choice Primary Care and such assistants as they may designate, to carry out diagnostic procedures if needed to better diagnose my condition and to administer such treatments and medications, as indicated. I understand that my condition may call for a consultation with another physician. If this situation occurs I authorize First Choice Primary Care to release medical information that may be needed to better provide for my medical treatment.

____ Initial **PAYMENT AGREEMENT**: The foregoing information is true to the best of my knowledge and I request First Choice Primary Care to provide my and/or my family with medical care. I acknowledge my responsibility to pay for services according to the policies established by First Choice Primary Care.

_____ Initial **Specialist Referral**: I understand that the discount program offered to eligible patients by First Choice Primary Care applies only to those services provided directly by First Choice Primary Care.

I also understand that if I am referred to a specialist, I will be responsible for the charges for those specialty services. Any payment arrangements or discounts offered by the specialist must be discussed with the specialist's office prior to my visit. While FCPC makes every effort to find low cost and accessible care, I understand that I remain responsible for payment of specialty care.

_____ Initial **Completion of Forms**: Request by patients to have forms completed should be made in advance. If you need a form completed, please furnish us with a copy of the form prior to your visit. Some lengthy forms will require a separate office visit to complete the required examination. If such a visit is required, regular office visit charges/copayments will apply. Please be advised that we cannot always complete these forms – some require the services of a specially certified person.

_____ Initial **Treatment of Chronic Pain Management and or treatment of Adult ADD/ADHD:** We do not provide narcotic Chronic Pain Management. We also do not provide medication management of adult ADD/ADHD.

Patient / or Guarantor Signature ____