

With this consent, Commonwealth Primary Care may e-mail to text me appointment reminders and patient statements.

By signing this form, I am consenting to Commonwealth Primary Care's use and disclose my PHI to carry out my treatment, payment, and operations activities.

I may revoke my consent in writing except to the extent that CPC has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, Commonwealth Primary Care may decline to provide treatment to me.**

Insurance Authorization: I authorize the release of any medical information to any insurance company, Medigap Insurance, third party administrator, or other payer that is necessary to process the claim and request payment of benefits either to myself or to CPC. I authorize CPC and its agents to release medical information contained in my medical record to any insurance companies, federal programs or state programs with which I am insured or who are responsible for payment of my claim. If applicable, I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf for any services furnished to me by or in CPC including physician services. I understand that I am financially responsible for all charges, whether or not covered by insurance. Also, if my account has to be turned over to an attorney or collection agency for collections, I agree to pay all costs of collection including attorneys' fees.

Assignment of Benefits: In consideration for healthcare and subsequent services provided to me by CPC, I hereby assign to CPC and any holder of medical or other information about me, and their agents, any and all rights, benefits, and claims I may have under any policy of insurance and the proceeds from any claim that I may have for injuries. Such assignment hereby authorizes direct payment to CPC under and/or from any such policy of insurance or proceeds.

I certify that I have reviewed this document in full, understand its terms, and have had the opportunity to ask questions regarding its contents. I understand that this document is valid and remains in effect unless revoked in writing by me.

PRINT PATIENT NAME: _____

PATIENT SIGNATURE _____ DATE _____

PARENT/GUARDIAN NAME (PRINT) _____
(If Patient is a minor, under age 18)

PARENT/GUARDIAN SIGNATURE _____ DATE _____