TRUCARE
FAMILY MEDICINE

RELEASE OF INFORMATION, BENEFIT ASSIGNMENT, PAYMENT AUTHORIZATION, FULL DISCLOSURE AND

AGREEMENT TO PAY FOR PROFESSIONAL SERVICES.

I hereby authorize TruCare Family Medicine, LLC to release any information necessary to process any insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim. I claim, direct, and authorize my carrier to issue payment check(s) directly to TruCare Family Medicine, LLC for any insurance benefits to which I am entitled. I understand that failure to disclose pre-certification/second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges as a result of non-payment by my carrier. I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary. I waive, now and forever, my right of exemption under the laws of the constitution of the State of Alabama and any other state. I understand that my insurance is filed as a courtesy, and I am responsible for the bill. I understand that I am responsible for paying any deductible, co-insurance, co-payment, or service deemed non-covered/patient responsibility, by my insurance carrier.

Date:_____ Signature of Patient or Guarantor:_____

EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE

You agree, in order for us to service your account or to collect monies you may owe, TruCare Family Medicine LLC, and/or our agents may contact you by telephone, at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages, and/or use of automatic dialing devices, as applicable. I/we have read this disclosure and agree that TruCare Family Medicine, it's employees and/or agents may contact me as described above.

Responsible Party:_____ Date:_____