Family Medical Associates of Raleigh
Your Family Comes First

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Patient Acknowledgment and Consent

MRN:_____

Patient Name:_____ DOB:_____

We are proud to be your Patient Centered Medical Home; please see our brochure in the lobby.
We offer same day appointments, extended office hours, and a provider on call 24/7 for urgent matters.

Consent for Treatment: I consent to treatment, examinations, procedures and diagnostic testing provided by Family Medical Associates of Raleigh (FMAR), which are deemed necessary.

HIPAA: I have been provided access to a copy of the Notice of Privacy Practices. I understand that my medical information may be required for payment of insurance benefits or by specialists that I have been referred to for my ongoing care.

Communication: I authorize FMAR to leave messages regarding my medical treatment at the numbers previously given **except for**: _____. I will notify FMAR if I would like to share my medical treatment information with any individuals and sign a Release of Information Authorization Form.

Prescriptions: I understand I need to provide a 48-hour notice for all medication refills and will notify my physician if I stop taking any medication.

Billing of Wellness Visits and Sick Visits: Visits for preventive wellness care such as adult physicals and Medicare wellness visits are separately billed from diagnostic and disease management care. I understand that additional evaluation of new problems, follow ups, and chronic conditions may be billed separately and processed at a different benefit level by my insurance than my preventive care.

Financial Responsibility: I have been provided access to a copy of FMAR's financial policy and understand I am financially responsible for all services provided at the time of service, including any amounts not covered by insurance. FMAR will take all necessary and appropriate action to collect any money due, including the use of collection agencies, and/or attorneys. My appointment may be rescheduled if I am unable to pay any current or past due balances.

Pharmacy Benefit Manager: I consent to allow my provider to access my pharmacy benefits, which are part of my insurance plan, in order to evaluate coverage for medications prescribed for me.

Patient Responsibility: I will act in a manner that is respectful of other patients, FMAR employees and clinic property. I will return at least every six months for a face-to-face follow-up visit with my provider if I take any maintenance or routine medications. I will notify my provider prior to stopping any medication prescribed.

Availability of Marketing Materials of Family Health and Wellness: Family Health and Wellness Center is a corporation founded by the owners of FMAR. As such, I acknowledge that FHWC materials, pamphlets, and posters are available throughout the office.

Patient Signature: _____ Date: _____