Maryland Primary Care Physicians **Administrative Consent**	**Patient Name** **DOB**: **SSN**: **MRN**: **CSN**: **Visit Date**: **TIME**:

Communication Preferences:

Would you like an appointment reminder: **YES** or **NO** (please circle one)

I,_____ **certify** that the information I have provided with regard to my insurance coverage is correct and further **authorize** the release of any necessary information, including medical information, to process any claim to Medicare, Social Security Administration and Health Care Financing Administration, and/or any other agents needed to determine benefits payable for related services. I **permit** a copy of this authorization to be used in place of the original. I hereby **authorize** any payments submitted to be made directly to Maryland Primary Care Physicians (or in case of Medicare B benefits to the party who accepts assignment) **I understand that authorization may be revoked by me at any time in writing.** I **understand** I am financially responsible for any balance deemed "patient" responsibility.

My signature below also **indicates my consent** for medical treatment of myself or

_____ [fill in patient name] as a patient of Maryland Primary Care Physicians, L.L.C.

_____ _____

Signature of subscriber, beneficiary, or responsible party and authority (e.g., POA, parent, etc.) Date

Please Initial

_____ Missed appointments and late cancellations reduce availability for other patients, increasing overall wait times. If you cannot attend a scheduled appointment, please inform us as soon as possible, ideally before the appointment day. You can cancel via telephone or MyChart. Frequent missed appointments may result in dismissal from the practice.

_____ I have read, understand, and agree with MPCP Financial Policy, ver 3.0 and accept responsibility for payment of all fees/charges incurred with Maryland Primary Care Physicians, LLC.

_____ My signature above also acknowledges receipt of MPCP/PMG Notice of Privacy Practices.

_____ I have read, understand and agree with Preventive Medical Visit Patient Information Policy, ver 3.0 and acknowledge that the provider may bill an additional charge for treatment of non- preventive medical problems in addition to the preventive exam