Gill Family Medicine
Health & Wellness

2422 Danville Road, Suite E
Decatur, Alabama 35603
(256) 355-9040

Consent Form

Please initial each line and sign at the bottom of the page and return to the front desk. Thank you.

_____ I am aware that Gill Family Medicine has a Notice of Privacy Practices that contains a section on Patient Rights. I have been given the opportunity to review this Notice and a copy is available upon my request.

_____ I understand that if I am uninsured or have an insurance that is not accepted at the practice, that I will be responsible for payment IN FULL at the time of service.

_____ I understand that co-pays are due at the time of service.

_____ I understand that I will be responsible for all charges incurred at the time of service if my deductible has not been met.

_____ I understand that I will be responsible for any charges that are not paid by my insurance company. Not all services are covered, and I understand that it is my responsibility to know the limits of my coverage and to pay any fees that my insurance company denies.

_____ I understand that it is my responsibility to know what lab my insurance requires me to use.

_____ I understand that it is my responsibility to know if my insurance requires a referral for any office visit and/or office procedure. It is my responsibility to confirm a referral is obtained. If I do not obtain a referral, I am responsible for any charges made to my account.

_____Please list the person(s), if any, we may speak with regarding your Protected Health Information.

Name	Phone Number	Relationship
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I agree, in order for Gill Family Medicine to service my account or to collect any amounts I may owe, that Gill Family Medicine may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I have read this disclosure and agree that the Lender/Creditor may contact me/us as described above.

Patient Signature _____ Date _____