 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

I have **read, understand, and agree** with MPCP Financial Policy, ver 2.0 and accept responsibility for payment of all fees/charges incurred with Maryland Primary Care Physicians, LLC. **Initials** _________

My signature above also **acknowledges receipt** of MPCP/PMG Notice of Privacy Practices. **Initials** _________

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. **Initials** _________