

Finger Lakes Family Care

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Request For Service Authorization & Personal Effects Release

1. I, the undersigned, (do) hereby authorize Finger Lakes Family Care to furnish ambulatory services to me (or if I am executing this agreement as a parent or guardian) and consent to the performance of such diagnostic studies, medical procedures, (including pelvic exam) or other treatment as may be ordered by physicians. For surgical or invasive procedures an additional consent form is required. Parent or legal guardian must be present at the time of surgical, invasive procedures, or immunization.

2. I hereby authorize Finger Lakes Family Care to release any information necessary as to my diagnosis and treatment to my insurance carrier and/or to any physician to whom I am referred for consultation.

3. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf payable to the physician furnishing the services.

4. I agree not to hold Finger Lakes Family Care responsible for any valuables or money I may bring to the office.

5. I understand the medical information of myself (and my child) is shared between the office, F. F. Thompson Hospital and covering physicians when appropriate.

6. I understand that I am financially responsible for all fees not paid by my insurance coverage and that any applicable copayments are due at the time of service. Finger Lakes Family Care will not bill for copayments or self pay amounts due at the time of service. I may be charged up to \$0.50 for each page of my medical record copied at my request or \$25, whichever is least.

7. I understand that Finger Lakes Family Care reserves the right to charge for missed appointments without 24 hours cancellation and to dismiss patients from the practice for either break-down of provider-patient relationship or non-payment of outstanding debts.

I have read the above, or it has been read to me, and I fully understand these statements.

Patient's (or guardian's) Signature:

Guardian's Name and Relationship:

Witness:

Date:

I acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices.

Patient's (or guardian's) Signature:

Guardian's Name and Relationship:

Witness:

Date:

I designate the following people as my personal representatives to be actively involved in my medical care. Names of such persons, with any restrictions if applicable, are listed below.

Patient's Name:

Patient's (or guardian's) Signature:

Date: