

Kristin Mahan APRN, FNP-C, LLC
620 Norwich New London Tpke
Uncasville, CT 06382
860-892-8012 phone/860-892-8027 fax

Consent For Treatment and Financial Responsibility

Please read and initial each item:

_____ If I have medical benefits, I will bring my valid insurance card with me to my visit. It is my responsibility to keep the practice informed of any changes to my coverage/benefits. I am aware I will be expected to pay my copay and any out of pocket expenses such as non-covered services (if I choose to have them performed), co-insurance and or/deductible at time of service.

_____ I understand that Kristin Mahan APRN participates with multiple insurance companies. The practice will submit my claim to my insurance. I authorize payment of medical claims to be made directly to the practice. I permit a copy of this authorization to be used in place of the original. As a courtesy, this office may agree to submit claims to my insurance even if we are non-participating with my plan. If Kristin Mahan APRN is non-participating with my plan, I understand that this office is not obligated to accept my insurance payment as full payment and I may receive a bill for the unpaid balance.

_____ If necessary, collection fees are added to delinquent accounts. I understand that I am responsible for any collection fees incurred on my account.

_____ I understand a service charge of \$25.00 will be charged to me if my check is returned for non-payment.

_____ I understand that it will be necessary for me to give a minimum 24 notice when cancelling an appointment. Repeated failure to comply will result in my being discharge from the practice.

_____ Permission is given to Kristin Mahan APRN, FNP-C, LLC and employees to perform routine diagnostic procedures, physical examinations, and to administer whatever routine treatment and/or services are deemed necessary for the diagnosis and treatment of my condition(s).

PATIENT NAME: _____ DATE: _____

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN):
