

PRESCRIPTION AND PHARMACY INFORMATION

Patients or Authorized Person's Consent -Physician requests permission to view patient's prescription history from external sources:

RX history consent

CONSENT SIGNATURE

RX HISTORY CONSENT DENIED

PHARMACY NAME

PHARMACY ADDRESS

PHARMACY PHONE

I hereby authorize and direct Primary Health Associates, P.C. and any member physician having treated me or my dependent, to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

I understand that I am responsible for all co-pays, co-insurance and deductible amounts set forth by my insurance carrier.

I understand that any personal outstanding balance that is 30 days or more past due will be subject to a finance charge of 1.5% per mo (APR 18%).

In the event my account is placed in collection status I will be responsible for all collection costs incurred in an amount not to exceed fifty percent (50%) of the unpaid balance. In addition, should any unpaid balance be referred to an attorney for litigation, all reasonable attorney fees and court costs shall be paid by you as allowed by the court. All returned checks will be assessed a \$35.00 returned check fee in addition to the original charge.

SIGNED: _____ DATE: _____