Welcome to Family Physicians of Spartanburg

We welcome you to our practice and look forward to the privilege of meeting your healthcare needs. Please don't hesitate to let us know at any time if we are not meeting your needs, or if you have questions. Below is some information about certain policies of our practice that you need to understand.

Collection of Patient Amounts Due

Insurance companies require that we collect any co-pay or co-insurance amounts at the time of service. We will collect the co-pay amounts at the time of check-in to avoid a wait at check-out. Please understand that you will be responsible for any amounts not paid by your insurance company.

Patients without insurance will need to make arrangements to pay their balance. We do offer a 40% discount for uninsured patients who pay at the time of service. We appreciate your assistance with this.

General Consent for Treatment

The patient, or designated representative, requests and authorizes this office to provide general medical care. This will include, without limitation, routine diagnostic procedures and medical treatments. If the patient is a minor, the individual signing below is indicating that they are the legal guardian and authorized to provide treatment.

Assignment of Payment

I hereby authorize payment of medical benefits directly to the practice for their services and to release any information acquired in the course of my examination or treatment for insurance purposes. I understand that records may be transmitted electronically or by mail as required.

Acknowledgement of Receipt of Notice of Privacy Practices

Your signature below acknowledges that you understand that your medical information will not be released to any individual unless indicated on the bottom of this form. This is in compliance with The Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Do you want to share your medical information with someone?
If you would like to authorize our office to share your medical information with a relative or someone else, you will need to list their name and relation in the space provided.

Name: ____ **Relation:** ________________________

Name: ____ **Relation:** ________________________

Name: ____ **Relation:** ________________________

Name: ____ **Relation:** ________________________

Signature of Patient, Parent, or Legal Guardian: ________________________ **Date:** _________