

Patient Responsibility Disclaimer

I, _____,

Legal Guardian of (if applicable), _____

Do understand that in order to cover this office visit, my medical insurance company may require a referral from my Primary Care Provider. I also understand that if

Fisher's Landing Urgent & Family Care has not received authorization for a referral from my Primary Care Provider, or in the case that my insurance policy does not cover my visit I will be financially responsible for any and all charges incurred, including labs, X-Ray and any other services rendered.

I understand that there will be a fee for any returned checks.

Labs: We are contracted with South West Washington Medical Center Laboratory. You may receive a separate statement from them for any laboratory testing performed at our clinic.

_____ Initial of Responsible Party

Acknowledgement of Privacy Practices

I have been given the opportunity to read and understand Fisher's Landing Urgent & Family Care's Policies of Privacy Practices.

_____ Initial of Patient or Parent/Guardian

Acknowledgement of Prescription Policies

I have been given the opportunity to read and understand Fishers Landing Urgent & Family Care's Prescription Refill Policy.

_____ Initial of Patient or Parent/Guardian

Signature of Responsible Party _____ Date _____