

**NextCare's Privacy and Billing Procedures  
Authorization and Acknowledgement**

These authorizations/acknowledgements cover all services rendered to me, or the patient I am signing for, today and all future dates of service. I understand I may revoke this authorization by informing NextCare in writing, but if I do revoke this authorization, it will not affect anything prior to the date the revocation is received by NextCare.

**Acknowledgement of Receipt of Notice of Privacy Practices  
Authorization to Release Information to Family/Friends or Others**

I have received a copy of NextCare's Notice of Privacy Practices. I authorize NextCare to release any information regarding my treatment; including lab results, x-rays, and medical records, to the following individuals/entities (NextCare may not release information or records to the names individuals/entities unless you identify them here):

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

NextCare will use my home phone number and primary address supplied during registration to contact me regarding my treatment; including lab results, x-rays, and medical records. I will ensure this information is up to date at every visit.

**Authorization to Treat and Bill**

I consent to be treated by NextCare. If I am not the patient being treated, I am authorized to consent to treatment and billing for the patient identified below. I authorize NextCare to bill my medical insurance for the care I receive and to release any information the insurance carrier requires to process this bill. I authorize payment of medical benefits to NextCare, or to outside labs as described below, for all services performed and billed by NextCare. I understand that I am responsible for all charges for the treatment I receive at NextCare. I understand that NextCare providers may utilize the Prescription Monitoring Program service at no additional charge to me.

As a courtesy, NextCare will bill my medical insurance. If I do not provide complete and accurate insurance information to NextCare, I understand NextCare may not receive payment for my carrier and I will be entirely responsible for my bill. Even after my medical insurance company pays NextCare's bill, I may owe NextCare payment for services not covered by my insurance and I agree to pay these promptly to NextCare. I understand that NextCare may send lab specimens to an outside laboratory. I authorize any lab performing services for me to bill my medical insurance for their services. I understand that my medical insurance may not pay for all services provided by the lab and I agree to pay any remaining balance promptly to any outside lab providing services to me. I understand that NextCare is not responsible for payment to outside labs for tests provided to me.

To protect my privacy and prevent fraud, I understand that if I cannot provide acceptable photo identification at the time of service, NextCare may choose not to bill insurance and may decline credit/debit cards and checks as a form of payment. I understand that if I fail to pay NextCare for services provided to me, the balance owed may be sent to collection and I may incur collection fees of up to 25% in addition to the amount owed for services/treatment rendered. I understand that I may contact NextCare to work out payment arrangements that may prevent this additional cost.

Signature \_\_\_\_\_ Today's Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Patient's Date of Birth \_\_\_\_\_

Name of Patient Representative \* \_\_\_\_\_ Relationship to Patient\* \_\_\_\_\_

\*(Required if the patient is a minor or if the patient is unable to sign this form.)