712 Putnam Pike, Unit 2
Chepachet, RI 02814

As a patient being treated at Stillwater Primary Care, I agree to the following terms:

- **I acknowledge that it is my obligation to make Stillwater Primary Care aware of any changes in my health insurance information. Should I fail to provide the necessary information to have my insurance claim properly adjudicated, I agree to assume full financial responsibility for services rendered to me by the provider. Further, should I neglect to make payment within 30 days of receiving a statement I understand that I may be responsible for interest, attorney fees and court costs. I also understand that delinquencies in payment are reported to a national credit reporting agency.**

- **I hereby acknowledge that I have presented myself for medical treatment. I authorize the providers(s) who are about to treat me to order and/or administer any treatment and or perform such procedures as may be deemed necessary or advisable in the diagnosis and treatment of my illness or injury. I further understand that these procedures, lab tests, x-rays, etc. may be at additional cost and by consenting to them I accept financial responsibility for payment of such. I acknowledge that all payments and co-payments are due at the time of service.**

- **I acknowledge that a $25.00 fee will be assessed for any returned checks. I also understand that I will be responsible for paying the amount of the original check plus the $25.00 fee in cash at the facility or I will be subject to collection/legal procedures.**

Assignment of Insurance Benefits:

I hereby authorize direct payment of medical benefits to Stillwater Primary Care for services rendered in person or under their supervision. I understand that I am financially responsible for any balance not covered by my health insurance.

I hereby authorize Stillwater Primary Care to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

A photocopy of these assignments shall be as valid as the original.

Patient Name (please print): _____ **DOB:** _____

Signature of patient or responsible party: _____ **Date:** _____

Witness: _____ **Date:** _____