



**ACKNOWLEDGEMENT RECEIPT
OF
ARKANSAS QUICK CARE POLICIES**

ARTICLE I: AQC POLICIES

By signing this form, I certify that I have read and understand the financial policies of Arkansas Quick Care, P.A and my financial responsibility. _____

ARTICLE II: MEDICARE AUTHORIZATION

By signing this form I verify that Arkansas Quick Care P.A. has been authorized to request payment from Medicare be made to me or on behalf of AQC for any service furnished me b this provider. Further, I authorize ay holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information to determine these benefits or the benefits payable for the related services. _____

(The above statement is for the Medicare beneficiary only)

ARTICLE III: INSURANCE BENEFITS AND INFORMATION RELEASE

By signing this form I hereby authorize Arkansas Quick Care to release any and all information concerning my diagnosis and treatment for the purpose of securing payment from my insurance company; and thereby authorize payment of the insurance benefits direct to Arkansas Quick Care for any service rendered that are not paid for directly by me. _____

ARTICLE IV: NOTICE OF PRIVACY PRACTICES

By signing this form I acknowledge that I have been given for review the six page document that explains the way my PHI (protected Health Information) is protected and may be disclosed. I have been given the opportunity to ask questions. A copy of this information is available in the patient area and I have been told that I may have a personal copy of this information upon request. _____

The above policies went into effect in this clinic on July 8th, 2013 and they may change with changes in the law. In this event the new policies will be dates on the date they were effective. The prior policies will be retired but maintained I the electronic and/or physical record of Arkansas Quick Care, P.A. should any questions or concerns arise.

I acknowledge that I have received and reviewed the documentation listed above, that I was given an opportunity to ask questions and I fully understand.

Patients Signature _____

Date _____