Family Care Clinic of Ripley

Wanda Stroupe, DNP-BC
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Lauren Babb, FNP-C
Bailey McNeese, FNP-C
Cynthia Haynes, FNP-C

Insurance Information Form:

Patient's Name: _____ **Date**: _____
First MI Last

Primary Insurance:
Insurance: _____
Insurance Address: _____ **City, State, Zip**: _____
Policy Holder: _____ **Policy Holder DOB**: _____
Policy ID: _____ **Group #**: _____

Please Note:
Our office will file primary & secondary insurance carriers for all reimbursable services.
Please remember that you are responsible for all **DEDUCTIBLES, CO-PAYS, & NON-COVERED SERVICE AMOUNTS**.

General Consent:
I, _____ (Initial Here) am voluntarily seeking medical treatment. I consent to examination by the Physician, Nurse Practitioner, Nurse, and other healthcare professionals at Family Care Clinic of Ripley. I also consent any medical procedures, x-rays, lab test(s), or other health care services ordered by my healthcare team. I understand that I may refuse specific treatments or procedures by informing my healthcare team.

Release of Information:
I authorize this clinic to release any information necessary to process my claim.
Assignments of Insurance Benefits and Acceptance of Financial Responsibility:
I authorize payment directly to the clinic. I understand and agree that if any part of my account is not paid by the insurance, I am financially responsible.

Patient or Authorized Person Signature: _____