Compass Primary Care
1720 Phoenix Blvd, Suite 700
College Park, GA 30349
470-369-7800

FINANCIAL PATIENT AGREEMENT

Patient's Name____ Date of Birth________________

Please read the following statements below and initial each one.
I hereby authorize Compass Primary Care, LLC to release any medical information necessary to process insurance claims. I certify that the insurance information provided is correct. Initials ________

Authorization to Pay Benefits: I hereby authorize and assign direct payment to Compass Primary Care, LLC medical benefits. I understand that I am financially responsible for charges not covered by this assignment.
Initials ________

I understand that Compass Primary Care, LLC does not bill patients for office visits or copays. Payment must be made at time of visit. Initials ________

I understand that I will be charged a cancellation fee for canceling an appointment less than 24 hours in advance. Initials ________

I understand that failure to keep an appointment will result in a "No Show" fee which must be paid before your next visit.
Initials ________

I understand that my insurance or healthcare plan may not provide coverage for items such as deductibles, co-payments, or non-covered services and that I am responsible for all services received. Initials ________

I have been given a copy of Compass Primary Care, LLC Notice of Privacy Practices to read.
Initials ________

Patient's Signature ______________________________________ Date ______________

Updated 3/21/2019