Request for Family Information

Main Line Family Medicine
1450 East Boot Road, Suite 200A • West Chester, PA 19380 • 610-344-9650

FAMILY MEMBERS: (Please list all family members living with you or for whom you are financially responsible)

Name	Relationship	Date of Birth
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CONSENT FOR MEIDICAL TREATMENT: Permission is hereby granted to the doctors, nurses, and employees of Main Line Family Medicine to do such procedures as may be necessary to diagnose, treat and care for the needs of myself or for my dependent for whom this form is completed.

Please remember that insurance is considered a method reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or agreement).

IN ORDER TO HELP CONTROL THE COST OF BILLING, WE REQUEST THAT YOUR PAYMENT BE MADE FOR ALL SERVICES AT THE BEGINNING OF YOUR VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE PRIOR TO SERVICES BEING RENDERED.

FINANCIAL RESPONSIBILITY: I agree to pay Providers accounts on myself and dependents when presented to me. I assign all payments directly to providers. I understand that I am financially responsible for all of the charges whether or or not they are paid by my insurance unless a legal document is presented bearing the name, address and phone numbers of the person financially responsible.

RELEASE OF INFORMATION: I authorize Providers to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier, any other commercial insurance company or employer sponsored health plan, any information needed for this or a related claim. A copy of this authorization may be used in place of the original. I hereby request payment of insurance benefits to the Providers.

AUTHORIZATION OF MINORS: I hereby authorize the following person(s) to present my above listed child/children for medical treatment from this date forth. This authorization is effective until written notice is giving by me to cancel said authorization.

Name	Relationship
Name	Relationship

CONSENT TO TREAT MINORS: By checking the boxes below you are giving us permission to provide or discuss:

[ ] Birth Control Services [ ] Pregnancy Testing

Signature (Patient or parent if less than 18 years of age)	Date