Carol A. Pelletier
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"I authorize Carol A Pelletier APRN, to furnish to my insurance carrier or other third-party payer information about my diagnosis and treatment necessary to process claims for payment. I acknowledge that Associates in Primary DNP Care bills my third party payer as a service to me and that I am financially responsible for all charges that are deemed not covered or not medically necessary. I am aware that separate services may be covered differently depending on my policy, which is my responsibility to understand. Interest, penalty, collection costs & legal costs incurred in order to obtain patient payment becomes the responsibility of the patient. I assign to Associates in Primary Care Medicine, Inc., all payments for medical services rendered. This assignment will remain in effect until I revoke it in writing. A photocopy of this assignment is as valid as the original."

1. By signing below, I acknowledge and accept the following:

2. Receipt of Carol A Pelletier APRN,DNP Notice of Privacy Practices.

3. **Consent to call:** I authorize Carol A Pelletier APRN,DNP, to contact me via phone, including automated messages.

4. **Consent to email and or text :** I authorize Carol A Pelletier APRN,DNP. to contact me via email.

5. **Consent to obtain medication history**: I authorize Carol A Pelletier APRN,DNP to download my medication history.

6. I acknowledge receipt of Carol A Pelletier APRN,DNP, Inc. no show policy and reasons for possible discharge policy.

Patient
Signature:_____
Date: _____

Please circle your preferences:

1. Health notifications: Email Phone Text
2. Appointments: Email Phone Text
3. Announcements: Email Phone Text
4. Billing: Email Phone Text