BRITT MOBILE MEDIC, PLLC
Office of Nicole Britt, FNP-C

Financial Policy

Britt Mobile Medic, PLLC

Thank you for choosing Britt Mobile Medic as your healthcare provider. Please review the following financial policies carefully. We require all patients to read and sign this agreement prior to receiving any service.

For Self-Pay Patients: I understand and acknowledge that I am financially responsible for payment in full for all services and supplies provided to me by Britt Mobile Medic. I agree to pay all fees prior to receiving services, as outlined by authorized clinic representatives. I understand that by choosing self-pay, I am requesting that no insurance claims be submitted on my behalf for these services. All laboratory tests or procedures must be paid for at the time of service. I acknowledge that any labs not paid for at the time of visit will not be submitted to the outside lab (Accu reference, Tens Health).

For Insured Patients: I understand that having health insurance is not a guarantee of payment for medical services rendered. I am responsible for verifying whether Britt Mobile Medic and/or Nicole Britt, FNP is an in-network provider with my insurance plan. If services are received out-of-network, I agree to be responsible for any uncovered or denied charges. I authorize direct payment of insurance benefits, including Medicare, to Britt Mobile Medic for any services or supplies provided. I confirm that I have provided accurate and up-to-date insurance information. I authorize the release of any medical or other information required to process claims or determine benefit eligibility to my insurance carrier, Medicare, or any third-party payer. I understand that I am financially responsible for any charges not covered by my insurance, including but not limited to co-payments, deductibles, non-covered services, and denied claims. I acknowledge that final determination of coverage may not occur until after a claim is processed. I accept responsibility for any balance determined by my insurer or Britt Mobile Medic. I agree to notify Britt Mobile Medic promptly of any changes in my insurance coverage to ensure uninterrupted billing and claim processing.

Office Payment Policy

- All patient financial responsibilities, including co-pays and deductible estimates, are due at the time of service.
- I understand that any unpaid balance beyond 60 days may result in my account being referred to a collections agency, and I agree to pay any associated collection fees.
- If I am unable to pay my balance within 60 days, I will contact the office to set up a monthly payment plan to avoid collections.
- By signing this agreement, I accept full financial responsibility for all services and supplies received from Britt Mobile Medic, as outlined above.

PATIENT/GUARDIAN ACKNOWLEDGEMENT

I have read the above Financial Policy. By signing below, I understand and agree to this financial policy.

Patient Signature: _____ Date: _____

Parent or **Guardian Signature:** _____ Date: _____

BRITT MOBILE MEDIC, 805 S MADISON STREET, WHITEVILLE, NC
OFFICE: 910-207-6393; FAX: 910-408-7670; MOBILE: 910-317-0003

Consent for Disclosure, Treatment, and Communication
Britt Mobile Medic, PLLC

(A **PHOTOCOPY** OF THIS DOCUMENT SHALL BE VALID AS ORIGINAL)

1. Authorization for Disclosure and Use of Protected Health Information (PHI):
I authorize Britt Mobile Medic, PLLC to request, access, and use my Protected Health Information (PHI) as needed for the purposes of medical treatment, billing and payment for services provided, and healthcare operations. This may include, but is not limited to, the following types of medical records: Progress notes and consultation reports; Prescription history; Laboratory and diagnostic test results; Imaging studies (e.g., X-rays, EKGs); Emergency department records; Hospital inpatient records; Advance directives (e.g., living wills, DNR orders). I understand that if my records contain sensitive information—such as mental health or psychiatric conditions, HIV/AIDS status, substance use history, or results of genetic testing—any use or disclosure of that information beyond treatment, payment, or healthcare operations will require additional specific authorization.

2. Consent for Medical Treatment:
I consent to receive medical evaluation and treatment from Britt Mobile Medic, PLLC and its designated healthcare providers, as deemed necessary and appropriate in accordance with standard clinical guidelines and best practices. This consent applies to both myself and any dependents under my care.

3. Assignment of Benefits:
I authorize payment of medical and/or surgical benefits directly to Britt Mobile Medic, PLLC for services rendered by its providers or under their supervision. I understand that I am financially responsible for any portion of fees not covered by my insurance plan or other third-party payers.

4. Acknowledgment of Privacy Practices:
I acknowledge that I have reviewed Britt Mobile Medic's Notice of Privacy Practices and have been given the opportunity to request a personal copy for my records.

5. Consent to Contact:
I understand and acknowledge that Britt Mobile Medic, PLLC may contact me regarding my care, follow-up appointments, or billing matters via the following methods: telephone (home or cell), mail, and email.

DISCLOSURE OF PHI TO FAMILY MEMBERS, ETC.

List the names of anyone that you would like to have access to your PHI:

_____ **Relationship**:_____

_____ **Relationship**:_____

I hereby authorize, acknowledge and consent to the above:

Patient Signature: _____ DATE: _____

Parent or Guardian: _____ DATE: _____

BRITT MOBILE MEDIC
805 S MADISON ST, WHITEVILLE, NC 28472

PATIENT REGISTRATION FORM

LAST NAME: _____
:
FIRST NAME: _____

MIDDLE INITIAL: _____

FORMER LAST NAME: _____

SEX: ☐**MALE** ☐**FEMALE**

DATE OF BIRTH: _____

SOCIAL SECURITY_____

PHYSICAL ADDRESS: _____

CITY:_____ **STATE:** _____

ZIP CODE: _____

HOME # _____

CELL# _____

WORK# _____

EMAIL: _____

EMERGENCY CONTACT-please list a different number from your contact

NAME:_____

PHONE:_____

RELATIONSHIP TO PATIENT:

RACE & ETHNICITY

☐ **PREFER NOT TO ANSWER**

RACE: _____

PREFERRED CONTACT METHOD

☐ HOME PHONE ☐ CELL PHONE

PATIENT MAILING ADDRESS (IF DIFFERENT THAN HOME)

MAILING ADDRESS: _____

CITY _____ **STATE** _____ **ZIP CODE** _____

MARITAL STATUS:

AUTOMATED COMMUNICATION

Please indicate if we can use our automated communication services to contact you via call, text and email.

☐ YES ☐ NO

BRITT MOBILE MEDIC
805 S MADISON ST, WHITEVILLE, NC 28472

RESPONSIBLE PARTY (Patients under **18** yrs old)

NAME: _____

BIRTHDATE _____

MAILING ADDRESS IF DIFFERENT (LIST BELOW)

ADDRESS: _____

CITY _____

ST _____

ZIP CODE _____

RELATIONSHIP TO PATIENT: _____

PRACTICE MISSION STATEMENT

At Britt Mobile Medic, we are committed to delivering compassionate, timely, and comprehensive **urgent and primary care** services—whether at home, in the workplace, or in our local clinic. As a faith-driven practice, we believe true healing involves the body, mind, and spirit. We will therefore, when deemed necessary, recommend certain screenings, tests and treatments that are consistent with standard medical practice. The patient is not obligated to accept our recommendations and may refuse any test and/or part of any exam. We respect your right to be informed and to refuse care. Our goal is to keep you safe, healthy and happy by doing our part to prevent, treat and/or control the many health conditions in our area.

PATIENT FOLLOW-UP RESPONSIBILITY

The **patient hereby** acknowledges that medical care requires active collaboration between the patient (and/or family as appropriate) and the healthcare provider. As an informed and engaged patient is key to a successful outcome, the patient has the responsibility to communicate openly and the responsibility to inquire within a reasonable time about the diagnostic tests and treatment plans that were ordered or recommended, and a duty to schedule a follow-up with the healthcare provider_____initials._

MY SIGNATURE IS CERTIFICATION THAT THE ABOVE INFORMATION IS CORRECT. I HAVE ALSO READ AND UNDERSTAND THE MISSION STATEMENT. A PHOTOCOPY OF MY SIGNATURE SHALL BE VALID.

PATIENT OR PARENT/GUARDIAN SIGNATURE:

DATE: