Adult and Pediatric Urgent Care

CONSENT, ASSIGNMENT, AND RELEASE FORM

CONSENT FOR MEDICAL TREATMENT

I voluntarily present to Adult and Pediatric Urgent Care consent to treatment of the physician on duty and whomever they may designate as their assistant, associate, treating physician and patient care staff to provide my care. Such care my include, but is not limited to, diagnostic procedures, radiological evaluations and procedures, and the administration of medications considered advisable in my diagnosis, treatment, and course of care. I acknowledge that no guarantee can be made or has been made as to the results of treatments or examinations and I understand that all medical treatments contain inherent risks.

ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT GUARANTEE

In consideration of services provided, I hereby assign and transfer to Adult and Pediatric Urgent Care any and all rights, which I have against insurance companies or third party payers, for payment of charges of services provided by Adult and Pediatric Urgent Care to me or to one of my dependents. I Authorize said payments to be applied to any unpaid balance for which I am responsible. I understand that I am responsible for and will pay the portion of my bill not covered by insurance companies and third party payers. I agree to pay the account in full upon receipt of my billing statement unless payment arrangements are made with Adult and Pediatric Urgent Care. If my account is placed with a collection agency, an additional 35% will be added to my balance. *It is our policy that any insurance co-pays and deductibles or any balance of a bill owed by those without insurance is due at the time of service.*

GOVERNMENT COMPLIANCE

In compliance with the recently enacted Patient Protection and Affordable Care Act and the Stark Law, Adult and Pediatric Urgent Care must inform you that there are other options pertaining to laboratory, diagnostic, and radiographic services. Specifically it should be noted that you have presented to Adult and Pediatric Urgent Care offers many of these services on-site as a convenience to our patients. If any patient would like to have their laboratory or radiographic services provided at another location we can provide you with a list of near by locations.

RELEASE AND USE OF PATIENT INFORMATION

I authorize the release of my medical records, information, and treatment and advice, and specific health information to:

1) TREATING PHYSICIANS on staff at Adult and Pediatric Urgent Care and their staff, agents of another healthcare facility if direct transfer to another facility is required, and to my primary care physician or any referred consultants for follow up care.
2) AN EMPLOYER who requests services. This may include your personal medical history, physical laboratory and diagnostic tests, and drug screenings (including the presence of drugs, alcohol or marijuana).
3) INSURANCE COMPANIES or other third party payer and their agents as well as any review organization or government agency for the purpose of determining eligibility and available benefits, obtaining payment for services provided, insuring government compliance.
4) EDUCATIONAL OR SCIENTIFIC INSTITUTIONS, authorized health care professionals in training, internal equality improvement, risk management and legal counsel when it is judged that my ongoing medical care, medical research, quality improvement, healthcare education or science will benefit, for any purpose authorized by law. I understand that if I refuse to authorize access to my records for coordination of care, my treatment could be adversely affected and that I could be held liable for the full cost of services provided by Adult and Pediatric Urgent Care. I understand this information my contain my personal medical history, physical, and treatments (if necessary), radiographic and laboratory results, and more specifically, results in reference to alcohol/drug abuse, mental health, or infectious disease (including human immune-deficiency virus, hepatitis, or other infectious diseases). I understand that I have the right to revoke this authorization.

Printed Patient Name______________________________

Signature of Patient or Parent/Guardian:______________________________

Date:_____/_____/_____