Date: _____/_____/_____

Patient Name: _____

Physicians Urgent Care
Emergency Physicians

CONSENT FOR MEDICAL TREATMENT

I voluntarily present to Physicians Urgent Care (PUC) and consent to treatment of the physician on duty and whomever they designate as their assistant, associate, treating physician and patient care staff to provide my care. Such care may 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.

NOTICE OF CLOSED CIRCUIT CAMERAS

For safety and security purposes Physicians Urgent Care may use closed circuit camera surveillance equipment. Closed circuit cameras are not equipped to receive or record audio. Cameras may be located in public areas of the clinic that include the lobby, hallways, entrances and exits. Cameras are not used or installed in patient care areas or private areas such as patient rooms, x-ray room or restrooms. Patient privacy will not be compromised or impacted.

ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT GUARANTEE

In consideration of services provided, I hereby assign and transfer to PUC any and all rights, which I have against insurance companies or third party payers, for payment of charges for services provided by PUC 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 or third party payers. I agree to pay the account in full upon receipt of my billing statement unless payment arrangements are made with PUC. I agree to pay all expenses in including collection and attorney fees applicable. I understand that my visit constitutes a credit transaction and such, PUC, or its agent (s), have permission to report unpaid balances to credit bureaus and may seek address and employment information as necessary to affect collection of any unpaid balance. I agree to pay a $30.00 fee for returned checks.

COLLECTION AT TIME OF SERVICE

At the end of each visit Physicians Urgent Care provides patients with an estimate of their portion of the bill. This estimate may consist of co-pays and/or deductible and/or co-insurance. Your estimated responsibility is due and collected at the end of the visit. A claim will be filed with your insurance company. If the insurance company's patient responsibility differs from the initial estimate, you will receive a statement for the remaining amount that you are responsible.

INITIAL HERE **By initialing, I agree to pay by way of VISA, MASTERCARD, DISCOVER, CHECK, OR CASH at the time of service.**

GOVERNMENT COMPLIANCE

In compliance with the recently enacted Patient Protection and Affordable Care Act and the Stark Law, PUC 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 PUC voluntarily for your medical needs and that as part of the evaluation of your condition and any required treatment, the physician on duty may determine that particular laboratory, diagnostic, and radiographic tests may be needed. PUC 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 nearby locations. Due to government laws and policies PUC is not able to accept payment of laboratory, radiographic, or other ancillary services from Medicare, Secondary Medicare Plans, or Medicaid. If you have Medicare or Medicaid as your primary or secondary insurance it is your responsibility to inform the staff of PUC of this so that we may explain this law and its ramifications in more detail to you.

RELEASE AND USE OF PATIENT INFORMATION

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

1. TREATING PHYSICIANS on staff at PUC 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 COMPANY 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, and ensuring government compliance.
4. EDUCATIONAL OR SCIENTIFIC INSTITUTIONS authorized health care professionals in training, internal quality 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 refusing 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 PUC. I understand this information may contain my personal medical history, physical, and treatments, 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 at any time.

Signature of Patient or Parent/Guardian: _____ **Date**: ____/____/_____