PhysicianNow URGENT CARE

Patient Name: _____ **DOB:** _____

Reason for visit: _____

CONSENT FOR MEDICAL TREATMENT

I voluntarily present for treatment and consent to my physician and whomever they may designate as their assistant, associate, treating physician and patient care staff to provide care to myself or my dependent. Such care may include, but not be limited to, diagnostic procedures, psychotherapeutic treatment, other treatments and medications, radiologic evaluations and procedures considered advisable in my diagnosis, treatment, and course of care. I acknowledge that no guarantee can be made or has been made as to results of treatments or examinations at Physician Now Urgent Care (PNUC).

RELEASE AND USE OF PATIENT INFORMATION

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

1. **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, available benefits and obtaining payment for services rendered.
2. **TREATING PHYSICIANS** on staff at PNUC, their agents and allied health professionals; to another health care facility upon direct transfer and to my consulting, referring and/or primary care physicians for follow up care. I understand that if I refuse to authorize access to my records for coordination of care, my treatment could be adversely affected.
3. **AN EMPLOYER** who requests services including history, physical exam, laboratory and diagnostic tests, and screening for the presence of drugs, alcohol or marijuana.
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, health care education or science will benefit; for any purpose authorized by law.

I understand this information concerning medical care, advice or treatment may include history and physical/ diagnosis/ laboratory and diagnostic testing, specific information concerning alcohol abuse/ mental health/ drug abuse/ human immunodeficiency virus/ hepatitis or other infectious diseases. I understand that I have the right to revoke this authorization. If my revocation prevents or reduces payment for services received, I become responsible for payment.

_____	_____
Printed Name	Date
_____	_____
Signature of Patient or Guardian	Relationship to Patient

COMMUNICATION / TEST RESULTS AND REPORTS

Our office commonly calls to check on patients a few days after their visit. Also, we may need to communicate test results and/or reports to you. Please indicate what phone number you would prefer us to call.

Phone #: _____

- ☐ You have my permission to leave a message at the above number regarding lab results and/or radiology reports. (Ex: normal strep or urine culture; normal x-ray report)
- ☐ You have my permission to discuss my medical care or account with _____
- ☐ Do not leave any messages on my voice mail or with anyone but me.

It is your responsibility to notify our office if you have any telephone number or address changes. If we are unable to reach you by telephone with abnormal test results, we will send you this information in a letter.

_____ _____

Signature of Parent or Guardian Date

ASSIGNMENT OF INSURANCE BENEFITS

In consideration of services provided by PNUC, I hereby assign and transfer to PNUC any and all rights, which I have against insurance companies, governmental agencies, or third party payers, for payment of charges for services provided by PNUC to me or my dependent.

FINANCIAL RESPONSIBILITY

I understand that I am ultimately responsible for determining if my insurance company contracts with PNUC and is considered "in" or "out" of network with my insurance company. I understand that I am responsible for and will pay co-payments, policy deductible, co-insurance and the portion of my bill not covered by insurance companies, governmental agencies or third party payers. I understand that I will be responsible for any charges incurred by not providing the most current, correct insurance and billing information to PNUC.
In consideration of services to be provided, I agree to pay PNUC in accordance with the regular rates and terms of PNUC. I further agree to pay the account in full upon receipt of my billing statement unless payment arrangements are made with PNUC. I authorize said payments to be applied to any unpaid PNUC balance for which I am responsible. If my account is placed with a collection agency, an additional 15% will be added to my balance. **I understand that I will be charged a fee of $30 for any returned check.**

_____ _____

Signature of Parent or Guardian Date

RECIEPT OF HIPAA NOTICE

I acknowledge receipt of the Notice of Privacy Rights (HIPAA) with detailed information about how Physician Now Urgent Care may use and disclose my protected health information. I understand that Physician Now Urgent Care reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

_____ _____

Signature of Parent or Guardian Date