CONSENT, RELEASE, ASSIGNMENT FORM

CONSENT FOR MEDICAL TREATMENT

I voluntarily present for treatment and consent to my physician and whomever they may designate, associate, treating physician and patient care staff to provide my care. Such care may include, but not be limited to, diagnostic procedures, psychotherapeutic treatment, other treatments and medications, pathologic and radiological 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 the results of treatments or examinations at Stony Creek Urgent Care.

RELEASE AND USE OF PATIENT INFORMATION

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

1) **AN EMPLOYER** who requests services (including history, physical, laboratory and diagnostic tests, and screening for the presence of drugs, alcohol or marijuana)
2) **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 provided.
3) **TREATING PHYSICIANS** on staff at Stony Creek Urgent Care, their agents and allied health professionals; to another healthcare facility upon direct transfer or referral; primary care physician, **provided the physicians name is listed on your Registration Form**. I understand that if I refuse to authorize access to my records for coordination of care, my treatment could be adversely affected.

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 immune-deficiency virus/hepatitis/or other infectious diseases. I understand that I have the right to revoke this authorization. If my revocation prevents payment or reduces payment for services received, I become responsible for payment.

ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT GUARANTEE

In consideration of services provided by Stony Creek Urgent Care, I hereby assign and transfer to Stony Creek Urgent Care any and all rights which I have against insurance companies, governmental agencies, or third party payers, for payment of charges for services provided by Stony Creek Urgent Care to me or to one of my dependents. I understand that I am responsible for and will pay the portion of my bill not covered by insurance companies, governmental agencies or third party payers. In consideration of services to be provided, I agree to pay Stony Creek Urgent Care in accordance with the regular rates and terms of Stony Creek Urgent Care. I further agree to pay the account in full upon receipt of my billing statement unless payment arrangements are made with Stony Creek Urgent Care. I authorize said payments to be applied to any unpaid Stony Creek Urgent Care balance for which I am responsible. I agree to pay all costs of collections, including reasonable attorney fees, on all past-due amounts. I further give permission to pull a credit report as needed should my account be turned over to an outside source for collection efforts. I understand that any checks returned by my financial institution will incur a $35.00 returned check fee. I understand that as a contractual obligation with insurance companies, all copays are due at the time of service. I understand that a $15.00 administration fee will be added to my account if I do not pay my copay at the time of service.

I give consent, authorize release, and assign benefits to SCUC. ____

PATIENT/GUARANTOR SIGNATURE

RECEIPT OF HIPAA PRIVACY NOTICE

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

____   ____

PRINTED PATIENT NAME   **DATE**

____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN

Office Use Only: I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.
Staff Initials: __________ Date:________ Reason:____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION (VERBAL AND COPIES) TO MEMBERS OF YOUR FAMILY, OTHER PROVIDERS OR OTHER INDIVIDUALS.

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996, in order for our providers or the staff of Stony Creek Urgent Care to give copies of and/or discuss your condition/exam/procedures/x-rays/labs with members of your family, or other individuals that you designate ***(Cardiologists, Endocrinologists, Urologists, etc),*** we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

I authorize Stony Creek Urgent Care to release any and all information, including verbal information, concerning my medical care to the following individuals:

___________________________ ________________________ _____________________ _________________
Name (please print) Title (MD, friend, sister, etc) Phone Number Fax Number

_________________________ ________________________ _____________________ ________________
Name (please print) Title Phone Number Fax Number

___________________________ ________________________ _____________________ _________________
Name (please print) Title Phone Number Fax Number

_____I **DO NOT** authorize Stony Creek Urgent Care to release any information concerning my care to any individual.

_____I authorize Stony Creek Urgent Care to leave a detailed message on my answering machine.

_____I **DO NOT** authorize Stony Creek Urgent Care to leave a detailed message on my answering machine.

____ _______________________
Your Signature Date

AUTHORIZATION TO DISCUSS FINANCIAL INFORMATION

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996, we must obtain your authorization to discuss financial information with members of your family or other individuals that you designate other than insurance companies or third party payers and their agents.

I authorize Stony Creek Urgent Care to verbally discuss financial information with:

____ ________________________ __________________________
Name (please print) Relationship Phone Number

____ ________________________ __________________________
Name (please print) Relationship Phone Number

____ ______________________
Your Signature Date