CONSENT, ASSIGNEMNT, RELEASE FORM

MONROE URGENT CARE

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 my care. Such care may include, but not 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 the results of treatments or examinations at Monroe 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 organizations or government agency for the purpose of determining eligibility, available benefits and obtaining payment for services provided.
(3) 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
(4) TREATING PHYSICIANS on staff at Monroe Urgent Care, their agents and allied health professionals; to another health care facility upon direct transfer and to my attending 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.

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 Monroe Urgent Care, I herby assign and transfer to Monroe 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 Monroe 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 Monroe Urgent Care in accordance with the regular rates and terms of Monroe Urgent Care. I further agree to pay the account in full upon receipt of my billing statement unless payment arrangements are made with Monroe Urgent Care. I authorize said payments to be applied to any unpaid Monroe Urgent Care balance for which I am responsible. If my account is placed with a collection agency, an additional 35% will be added to my balance.

I give consent, and authorize release, and assign benefits to Monroe Urgent Care:_____

Patient/Guarantor Signature

Emergency Contact Name: _____

Emergency Contact Phone #:_____

RECEIPT OF HIPPA PRIVACY NOTICE-

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

_____ _____

Printed Patient Name Date

_____

Signature of Patient or Parent/Guardian

Office use only: (To be completed only when patient declines to sign acknowledgment):

_____ Check here if patient declined to sign acknowledgement _____ Staff Initials _____ Date