



## **PATIENT CONSENT ASSIGNMENT AND AUTHORIZATION FOR TREATMENT AND NOTIFICATION OF CENTER POLICIES**

### **CONSENT TO MEDICAL CARE AND TREATMENT**

While at The Urgent Care Center of Richmond Hill (UCCRH), I 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 be limited to, all medical and surgical care, examinations and diagnostic tests and procedures, other treatments and medications, pathologic and radiological evaluations and procedures determined to be necessary for my diagnosis, treatment, and course of care. Though I expect the care given will meet customary standards, I understand there are no guarantees, and no guarantees have been made concerning the results of my treatment, examination or care. In addition, if I refuse treatment that is suggested for me or do not complete any treatment protocol recommended to me, I will not hold The Urgent Care Center of Richmond Hill or any individual responsible for any of the consequences.

### **PHYSICIAN ASSISTANTS**

The UCCRH utilizes physician assistants to provide physician services delegated in accordance with state law. A physician assistant is a skilled healthcare provider who is licensed to a supervising physician and who is qualified by academic and practical training to provide patients' services not necessarily within the physical presence but under the personal direction or supervision of the supervising physician. In the course of your treatment you may be given a prescription drug or device, and you have the right to see the supervising physician or alternate supervising physician prior to this order being carried out.

### **RELEASE OF INFORMATION**

I understand The UCCRH may use health information for a range of purposes including but not limited to: insurance/payment eligibility verification, billing and collecting moneys due from me, private and public payors or their agents including insurance companies, managed care entities, my employer, state and federal government programs and the Bureau of Workers' Compensation; obtaining quality of care assessment and improvement activities; evaluating the performance or qualifications of physicians and health care workers; conducting medical and nursing training and education programs; conducting or arranging for medical review and audit services; ensuring compliance with legal, regulatory and accreditation requirements, and; public health activities. I authorize The UCCRH to receive or release my health information, whether written, verbal, electronic including secured internet web sites, or by facsimile to such employees, agents or third parties as are necessary for these purposes and to companies who provide billing services for physicians or other providers involved in my medical care.

I understand that complete, accurate health information must be readily available for my medical care. Therefore, I authorize The UCCRH to release health information to treating physicians or other providers or agencies affiliated or subcontracted with The UCCRH, as well as consulting or referring physicians or agency(ies), as well as my primary care physician, specialists, other health care facilities or agency(ies) in order to facilitate continuity of care. I understand that the information shared with health care professionals as a result of this authorization will remain confidential. I understand that if I refuse to authorize access to my records for coordination of care, my treatment could be adversely affected. The preceding authorizations for release of medical information include authorization for the release of information regarding history and physical/diagnosis/laboratory and diagnostic testing/specific information concerning drug and/or alcohol abuse, HIV (Human Immunodeficiency Virus) testing or HIV infection related conditions or other infectious diseases. This authorization shall remain valid for one year, and this authorization is revocable if requested in writing. If my revocation prevents payment or reduces payment for services rendered, I become responsible for payment.

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received or been offered a copy of The UCCRH Notice of Privacy Practices and have had a chance to object to the use or disclosure of my information for disaster relief or to provide information to family or persons involved in my care.

**ASSIGNMENT OF INSURANCE BENEFITS**

In consideration of services provided by The UCCRH, I hereby assign and transfer to The UCCRH any and all rights, which I have against insurance companies, governmental agencies, or third party payers, for payment of charges for services provided by The UCCRH to me or to one of my dependents. I authorize payment of all insurance benefits to be made directly to The UCCRH for services provided to me. I understand that benefits could be paid directly to me if I did not provide this authorization.

**FINANCIAL RESPONSIBILITY**

I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance, governmental, or third party benefits. I understand that charges due by the patient, but not paid within 30 days of billing may be subject to interest. In consideration of services provided, I agree to pay The UCCRH in accordance with the regular rates and terms of The UCCRH. I further agree to pay the account in full upon receipt of my billing statement. If my account is placed with a collection agency, an additional 25% will be added to my balance to cover the collection fee service. I understand that services rendered to me may not be eligible for benefits under Medicare or other insurance or payors. Services not eligible for benefits may include tests and procedures that are not covered, or those services my physician determines medically necessary, but are later determined unnecessary by my insurance plan.

**PARTICIPATION WITH HEALTH CARE PLANS**

The UCCRH currently has signed agreements with most major health plans. If you are a member of these Health Plans, you are probably utilizing UCCRH as an "In-Network Provider". UCCRH agrees to accept your Plan's payment as "payment-in-full", unless an item is identified to you and UCCRH as "non-covered" under your Plan or a co-pay or co-insurance that is your responsibility. **Participating Health Plans: Aetna Healthcare, Blue Cross Blue Shield, CIGNA Healthcare, Coventry Healthcare, First Health Network, Humana Choice Care, Humana Military (Tricare), Mail Handlers, Medicare Part B, Medicare Railroad Retirees, Memorial Health Partners including CBCA (Gulfstream) (January 1, 2012), and United Healthcare.**

We are not currently in network with **The Care Network** (Ga Ports/Savannah Business Group). We have expressed our interest in becoming an in-network provider with them MANY times. **Please express YOUR interest to your employer and your insurance representative.**

If you are not covered by one of the plans we are currently in network with, ask about our courtesy "Out of Network" cash discount. We will also be glad to assist you by providing the information needed by your plan to reimburse you under "Out-of-Network" benefits.

**Visit co-pays should be paid by you at the time of your visit.** We will later bill you for any co-insurance amount that is identified to us on your Plan's Explanation of Benefits. **Tricare Prime** patients are responsible for obtaining a retroactive referral from their Primary Care Manager for their visit at UCCRH.

**PERSONAL VALUABLES**

I understand that The UCCRH does not accept responsibility for any lost, stolen or damaged personal items. I accept responsibility for those items I choose to keep with me while at The UCCRH offices.

**I have read and understand the information outlined above:**

Patient/Guarantor Signature: \_\_\_\_\_ Date: \_\_\_\_\_