CONSENT TO MEDICAL SERVICE/
MEDICAL SERVICES AGREEMENT TERMS AND CONDITIONS

PATIENT NAME: _____

CONSENT TO MEDICAL SERVICE

The undersigned consents to the procedures which may be performed, including emergency treatment or services, and which may include but are not limited to laboratory procedures, x-ray examination, medical treatment or procedures, services rendered to the patient under the general and special instructions of the patient's physician, and to participate in the patient and employee protection program.

RELEASE OF INFORMATION

The urgent care may disclose all or any part of the patient's record to any person, company or corporation which is or may be liable under a contract to the urgent care or to the patient or to a family member or employer of the patient for all or part of the urgent care charge, including but not limited to hospital or medical service companies, insurance companies, workman's compensation, or welfare funds. The patient's records may be forwarded to the primary care physician or to another facility in the event of transfer.

ASSIGNMENT OF BENEFITS

Insurance is billed as a courtesy to the patient and is not an obligation. The undersigned authorizes, whether he/she signs as agent or as patient, direct payment of any insurance benefits otherwise payable to or on behalf of the undersigned for these outpatient services, including emergency services if rendered. It is agreed that payment to the urgent care, pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment and any applicable co-payments, co-insurances or deductible amounts.

FINANCIAL RESPONSIBILITY

In the event that the patient was evaluated by a Physician, Physician Assistant and/or Nurse Practitioner at the Urgent Care and was advised to go to another facility or Physician for further treatment and evaluation, the undersigned agrees that they are responsible for any applicable co-payments, co-insurance or deductible amounts.

By: _____ _____

It's duly authorized Representative — Patient's Agent or Representative

Date: _____ Time _____ _____

Relationship to Patient

I agree to accept full financial responsibility for services rendered to the patient and to accept the terms of the assignment of insurance benefits.

_____ _____ _____ _____

Date — Time — Financially Responsible Party — Interpreter