CONSENT & CHIEF COMPLAINT

Patient Name: _____ Date of Birth: _____ / _____ / _____

Chief Complaint: (Primary reason for your visit today) _____

Is Chief Complaint related to an Accident? [ ] No [ ] Yes (If Yes checked, please complete section below)

(Please check one) [ ] Work Related [ ] Auto [ ] Other Date Occurred: _____/_____/_____

Pharmacy Preferred Today: _____ Location: _____

Primary Care Physician: _____ Phone: (_____) _____ - _____

How did you hear about us? [ ] Friend/Relative [ ] Online [ ] T.V. [ ] Billboard

[ ] Magazine/Newspaper [ ] Location [ ] Physician Referral [ ] Other: _____

Consent for Treatment | Use of Protected Health Information | Financial Obligation

I hereby consent to medical evaluations, testing, and/or treatment provided by the staff of this medical facility. I understand the benefits, risk and possible side effects of receiving medications and vaccines and that it is my responsibility to provide any information relevant to health history, possible medication interactions and allergies.

I acknowledge that I have reviewed the company Payment Policy and have been given the opportunity to ask questions and have concerns and written request addressed.

I hereby authorize the facility to accept assignment of contracted insurance benefits and I understand that I am responsible for co-insurance, co-payments, and/or deductibles at the time of service. I understand that if my insurance is a non-contracted plan (out-of-network), the facility will courtesy file the claim for services rendered and any monies received by the facility will be reimbursed to me. In the event that I have no insurance coverage, I understand that fees are due at the time of service. I understand that the facility has the right to withhold discharge paperwork and prescriptions in the event of non-payment. I understand that previous balances owed to the facility will be requested at time of registration and any outstanding balance will be billed with accrued interest. I understand that the facility may be contracted with specific Medicaid plans. If my plan is not under contract with the facility, I may elect to accept sole responsibility for the payment of services, and the facility nor I may seek reimbursement from Medicaid for charges incurred.

I understand that if the provider has ordered additional laboratory test that the collected specimens will be sent to a local laboratory for testing. The facility will forward my payer information to the laboratory, but I will be responsible for the charges incurred for these services and will receive a separate bill from the laboratory. I understand that there may be a portion of the cost of Durable Medical Equipment that is not covered by my insurance company and I will be responsible for the balance.

I understand that the company may use or disclose my Protected Health Information (PHI) necessary to carry out treatment, payment, or healthcare operations or in other instances as permitted by HIPAA. For treatment purposes, the facility may request and utilize my medication history from other health care providers or third party pharmacy benefit payers. I hereby authorize the facility to e-prescribe my prescriptions. I understand that the provider may use photographs of my injury, wound, etc. for treatment consultation or specialist referrals. I understand that the address and email I provide may be used to provide me with information on health related benefits and services that may be of interest to me, as well as marketing and fundraising material. I understand that I have the right to opt out or unsubscribe to any information or materials that I may receive.

I acknowledge that I have been provided the Notice of Privacy Practices and Patient Rights and Responsibilities and have had the opportunity to ask questions, file a complaint to have concerns addressed, submit special written request and to object to the release of my PHI to a specific person if I so choose.

X _____ Date: _____ / _____ / _____

Signature of Patient/Guardian/Accompanying Adult