Medical Center Urgentcare

General Conditions of Admission, Consent, Assignment of Benefits & Financial Agreement

Patient: ____ Social Security Number: ____________________

Date of Birth: ________________ Healthcare Providers (primary care/specialists):____

Consent to Diagnostic Tests, Medical Treatment and Procedures:
I do voluntarily consent to care involving diagnostic tests, medical treatment and procedures by the physicians/practitioners of Medical Center Urgentcare d/b/a Commonwealth Health Corporation, their assistants and designees, and other employees of Medical Center Urgentcare as is necessary or advisable in their judgment. This consent includes testing for communicable diseases, including but not limited to Human Immunodeficiency Virus (HIV), hepatitis or any other blood-borne infectious disease if ordered for a diagnostic purpose or due to occupational exposure of a healthcare worker. I acknowledge no guarantee has been made to me as to the results of examination and treatment.

Assignment of Benefits and Financial Agreement:
I certify all information given by me is correct and I accept responsibility for the charges for the care provided. I agree to the assignment of all third-party benefits to Medical Center Urgentcare and to any physician, practitioner, organization or independent contractor who provided products or services, and agree to pay all charges not covered by third-party payers. If I am covered by an ERISA plan, with this assignment I specifically authorize my providers to receive copies of all notifications and information that I am legally entitled to receive under the terms of my insurance/health plan and to act on my behalf to appeal benefit determinations. I acknowledge any claim for benefits from a third party payer may be filed by Medical Center Urgentcare as a courtesy to me. However, I am primarily responsible for monitoring the filing process and making certain the claim is filed in compliance with the provisions specified by the applicable third party payer. The filing of the claim by Medical Center Urgentcare in no way releases me from liability for any portion of the bill not paid by a third party payer for any reason.

Unless other payment arrangements are approved by Medical Center Urgentcare, the account balance is due upon demand. Failure to pay for the services may result in the placement of an account with a collection agency or attorney for collection. All amounts due, as shown in the final statement and/or amended final statement, shall bear interest from the due date until paid at a per annum rate of eight percent (8%). In the event there is a judgment, the amount due shall accrue interest at the judgment rate of twelve percent (12%) until paid in full. Further, I agree to reimburse Medical Center Urgentcare for all costs of collection, including attorney fees and court costs.

Contact Information:
I agree Medical Center Urgentcare, Commonwealth Health Corporation and their agents, attorneys or collection agencies may contact me regarding medical information or information about my account or for the purposes of collection by telephone at any number provided by me including wireless telephone numbers, and via text messaging or e-mail to any e-mail address provided. Methods of contact may include the use of pre-recorded or artificial voice messages and/or automated dialing.

Release of Information:
I authorize the release of all or part of my records, including information stored in the Medical Center Urgentcare corporate-wide database, to my physician(s), whose name I provided at the time of registration, and to any physician or practitioner who has or will provide services to me. I authorize the release of statistical information as required by any local, state or federal agency or managed care program. I authorize the release of my HIV test results to health care personnel in the event of an occupational exposure.

I authorize Medical Center Urgentcare and any other holder of medical or other information to release information about me (including medical information concerning psychological or psychiatric conditions, alcoholism and/or drug related conditions and HIV or other blood-borne infectious diseases) as required to complete any claim for benefits due to services rendered to me to any person or corporation which is or may be responsible for all or part of the total charge incurred. The persons or corporations to which this information may be released includes, but is not limited to insurance companies, the Social Security Administration, its intermediaries and carriers, state agencies and workers' compensation carriers, as well as the review organization employed by my employer or the employer of the insured member of my family and any corporation engaged by Medical Center Urgentcare to make collection of any unpaid charges. I further authorize my employer to release to the Medical Center Urgentcare or any agency engaged for the purpose of collecting any unpaid charges, verification of my employment status, including the amount of salary or wages and the number of hours worked.

_________ *(initial)* I acknowledge I have been given the NOTICE OF PRIVACY PRACTICES.

_________ *(initial)* This authorization is valid for one year from the date signed or until revoked in writing.

_________ *(initial)* I understand there are benefits and risks associated with taking controlled substances, including the risk of developing drug tolerance or dependence. I am aware of the risks, benefits and alternatives. I consent to treatment with a controlled substance if my doctor deems it appropriate.

____________________	__________	__________	____________________
Signature	*Date*	*Time*	*Relationship (if not patient)*

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Witness

Original - Chart *Copy - Patient*

GENERAL CONDITIONS OF ADMISSION
UC-034 (12034) Rev. 06/15