Memorial Urgent Care
120 Coleman's Crossing Blvd., Marysville, OH 43040
937 578 4310
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PATIENT CONSENT AND AUTHORIZATION

1. **CONSENT TO MEDICAL CARE AND TREATMENT**: While at Memorial Urgent Care I consent to all medical and surgical care, examinations, and tests determined to be necessary. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. If I refuse suggested treatment, or if I leave against medical advice, I will not hold Memorial Urgent Care or any individual responsible for any of the consequences.
2. **RELEASE OF INFORMATION:** Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Your Rights section describing your rights under the law. You have the right to review our Notice before signing this consent and authorization. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.
3. **ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICE:** I acknowledge that I have received or been offered a copy of Memorial Urgent Care's Notice of Privacy Practices and have had a chance to object to the use or disclosure of this authorization.
4. **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize payment of all insurance benefits to be made directly to Memorial Urgent Care for services related to this visit. I understand that benefits could be paid directly to me if I did not provide this authorization.
5. **MEDICARE PATIENT'S RECORD OF SIGNATURE, PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title VXIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration Centers for Medicare or Medicaid Services (CMS), or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I also hereby authorize my signature to this document to be maintained on file by Memorial Urgent Care as part of its permanent record.
6. **NOTICE OF INDEPENDENT CONTRACTOR STATUS OF PHYSICIANS AND OTHER PROVIDERS:** Memorial Urgent Care is not responsible for the act, omission, diagnosis, or care rendered by physicians and other healthcare providers such as radiologists, pathologists, internists, and family practice physicians, each of whom is furnishing services to Memorial Urgent Care patients as an independent contractor and not as an employee or agent of Memorial Urgent Care.
7. **FISCAL RESPONSIBILITY:** I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance benefits. I agree to pay Memorial Urgent Care for charges incurred including incidentals. I understand that services rendered to me may not be eligible for benefits under Medicare, Medicaid, or other insurance or payers. Services not eligible for benefits may include tests and procedures that are not covered, or those delivered by healthcare providers who do not participate with my insurance plan. Non-covered services may also include those my physician determines medically necessary, but are later determined unnecessary by my insurance plan.
8. **PERSONAL VALUABLES:** I understand that Memorial Urgent Care does not accept responsibility for any lost, stolen, or damaged personal items.
9. **ALTERNATIVE MEANS OF COMMUNICATION:** The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of their home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER: (check all that apply)

O Phone Number _____ O Written Communication to my home address

O Phone Number _____ O Written Communication to my work/other address

I understand that requesting this alternative method of communication may interfere with Memorial Urgent Care's ability to contact me in medical emergencies. I understand and agree that, if I cannot be located by the alternative method requested, Memorial Urgent Care may use any available contact information to locate me in the event that:

- Memorial Urgent Care determines there is a medical emergency or similar situations in which my health is at risk if I am not contacted immediately.
- Memorial Urgent Care needs to obtain adequate information on how payments will be made, if this is not provided at the time of the visit.

I have read and understand the above patient consent and authorization form. A copy may be given upon request.

_____ _____
PATIENT NAME (please print) DATE PATIENT OR PATIENT REPRESENTATIVE SIGNATURE DATE

_____ _____
WITNESS SIGNATURE DATE IF SIGNED BY REPRESENTATIVE, RELATIONSHIP TO PATIENT

_____ _____
REASON FOR VISIT FAMILY PHYSICIAN