Patient Privacy, Financial Responsibility, and Treatment Consent

HEALTH CHOICE URGENT CARE

Patient Name _____ Date of Birth _____

Medical Records	
Notice of Privacy Practices	You may request to read and/or be provided with a copy of our full Notice of Privacy Practices.
Record Sharing Permission	If you want your medical condition(s), or information regarding your treatment verbally discussed with a family member, guardian, representative, or other non-medical non-financial guarantor, you will need to provide their name and relationship in writing or via electronic registration.
Work Related Records	When you are provided with work related injury, illness, or occupational services, and your employer is financially responsible for the visit, your visit records will be provided directly to the employer and/or employer's TPA/work comp Carrier. We are unable to share drug screen results directly with patients.
Records Sent to PCP	When you provide your Primary Care Provider's (PCP) information, we will automatically share a copy of today's visit notes with your PCP following this visit.

Communication	
Text and Email	When you provide us with your mobile phone and/or email address, we will use text messages and/or emails to communicate non-sensitive medical information. Some of the reasons we may text or email include: obtain feedback on your experience, follow up on your care, collect payment for services rendered, or communicate facility or service updates. You may Opt out of these services by following the instructions to Opt out in the text and/or email.
Voicemail	We may call you regarding treatment or testing results but will not leave sensitive medical information on a voice mail, such as the testing results, unless explicitly requested to do so.
Patient Portal	When you provide us with your email address, we will automatically send a copy of today's visit notes to your Secure Patient Portal. You may request additional documentation, such as lab results, be sent to your portal.

Financial	
Private Insurance	**Responsibility** - As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. **Copay, Deductible, co-insurance** - All patient co-pays, co-insurance, and/or deductibles must be paid at the time of service. **Card on File** - If you agree to reserve a credit card on file to cover any remaining patient responsibility not met at time of service, your card will be automatically charged the amount responsible (not to exceed $150) after we receive the Explanation of Benefits (EOB) from your insurance company.
Work Related Visits	Your employer or employer's workers compensation carrier will be billed for services as authorized. It is your responsibility to provide us with accurate information required to bill, such as employer or carriers name, address, contact information, policy and/or claim numbers, etc..
Self-Pay /Patient Responsibility	Payment for self-pay services, as well as remaining patient responsibility balances from prior visits, are due before services are rendered

Treatment	
Antibiotic Stewardship	Our providers are trained to provide the most medically appropriate and responsible care possible. Sometimes medication/antibiotics are not the best course of treatment based on your current symptoms or lab results. We make an effort to avoid unnecessarily prescribing antibiotics that could negatively affect your health.
Testing and Treatment	We will perform reasonable and necessary medical examinations, testing and treatment based on your specific diagnosis. You have the right to discuss the treatment plan with your provider, as well as the purpose, potential risks, and benefits of any test ordered for you. A provider may determine that we do not have the appropriate equipment or specialization to provide the medically necessary care you require. In those cases, you will be billed for the evaluation, clinical guidance, and/or coordination of your transfer.

My signature on this form acknowledges that I both understand and consent to related to Patient Privacy , Medical Records, Communication, Financial, and Treatment, Policies and Practices addressed , and I agree to the outlined terms.

Responsible Party Name _____ Responsible Party Signature _____ Date /Time _____