Patient Authorization

NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of the Notice of Privacy Rights with information about how Velocity Urgent Care may use and disclose my protected health information. I understand that Velocity Urgent Care reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

_____ _____
Printed Patient Name Date

_____
Signature of Patient or Parent/Guardian

CONSENT FOR MEDICAL TREATMENT

I consent to my physician and whomever they may designate to provide my care. Such care may include, but not be limited to, diagnostic procedures, radiological evaluations, medications and procedures considered advisable in my diagnosis, treatment, and course of care. I acknowledge that no guarantee can be made or has been made as to the results of treatments or examinations at Velocity Urgent Care.

_____ _____
Printed Patient Name Date

_____
Signature of Patient or Parent/Guardian

RELEASE AND USE OF PATIENT INFORMATION

I understand this information concerning medical care, advise or treatment may include history and physical/diagnosis/laboratory and diagnostic testing/specific information concerning alcohol abuse/mental health/drug abuse/human immune-deficiency virus/hepatitis/or other infectious diseases. I understand that I have the right to revoke this authorization. If my revocation prevents payment or reduces payment for services received, I become responsible for payment.

I authorize the release of my medical records, information, treatment and advice, and specific health information to:
1) AN EMPLOYER who requests services (including history, physical, laboratory and diagnostic tests, and screening for the presence of drugs or alcohol)
2) INSURANCE COMPANY or other third party payer and their agents as well as any review organization or government agency for the purpose of determining eligibility, available benefits and obtaining payment for services provided.
3) EDUCATIONAL OR SCIENTIFIC INSTITUTIONS authorized healthcare professionals in training, internal quality improvement, risk management and legal counsel when it is judged that my ongoing medical care, medical research, quality improvement, healthcare education or science will benefit; for any purpose authorized by law.
4) TREATING PHYSICIANS on staff at Velocity Urgent Care, their agents and allied health professional; to another healthcare facility upon direct transfer and to my attending consulting, referring and/or primary care physicians for follow up care. I understand that if I refuse to authorize access to my records for coordination of care, my treatment could be adversely affected.

_____ _____
Printed Patient Name Date

_____
Signature of Patient or Parent/Guardian

ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT GUARANTEE

I give consent, authorize release, and assign benefits to VUC

In consideration of services provided by Velocity Urgent Care, I hereby assign and transfer to Velocity Urgent Care any and all rights which I have against insurance companies, governmental agencies, or third party payers, for payment of charges for services provided by Velocity Urgent Care to me or to one of my dependents. I understand that I am responsible for and will pay the portion of my bill not covered by insurance companies, governmental agencies or third party payers. In consideration of services to be provided, I agree to pay Velocity Urgent Care in accordance with the regular rates and terms of Velocity Urgent Care. I further agree to pay the account in full upon receipt of my billing statement unless payment arrangements are made with Velocity Urgent Care.

_____
Patient or Guarantor Signature

I authorize said payments to be applied to any unpaid Velocity Urgent Care balance for which I am responsible. If my account is placed with a collection agency, an additional 30% will be added to my balance.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION (VERBAL AND COPIES) TO MEMBERS OF YOUR FAMILY OR OTHER INDIVIDUALS

I authorize Velocity Urgent Care to release any and all information (including verbal information, copies of x-rays and medical paperwork) concerning my medical care to the following individuals:

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996, in order for your physician or the staff of Velocity Urgent Care to give copies of and/or discuss your condition/exam/procedures/x-rays with members of your family or other individuals that you designate other than your primary care doctor or specialist, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____

Name (please print) Relationship Phone Number

_____

Name (please print) Relationship Phone Number

_____I DO NOT authorize Velocity Urgent Care to release any information concerning my care to any individual.
_____I authorize Velocity Urgent Care to leave a detailed message on my answering machine.
_____I DO NOT authorize Velocity Urgent Care to leave a detailed message on my answering machine.

_____

Your Signature Date

AUTHORIZATION TO DISCUSS FINANCIAL INFORMATION

I authorize Velocity Urgent Care to verbally discuss financial information with:

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996, we must obtain your authorization to discuss financial information with members of your family or other individuals that you designate other than insurance companies or third party payers and their agents.

_____

Name (please print) Relationship Phone Number

_____

Name (please print) Relationship Phone Number

_____

Your Signature Date

Office Use Only: (To be completed only when patient declines to sign for receipt of the Notice of Privacy Rights)
_____Check here if patient declined to sign _____Staff Initials _____Date