



Urgent Care Center

Quality Care Quickly

**CONSENT, ASSIGN, RELEASE FORM**

**CONSENT FOR MEDICAL TREATMENT:** I voluntarily present for treatment and consent to my physician and whomever they may designate as their assistant, associate, treating physician and patient care staff to provide my care. Such care may include, but not be limited to, diagnostic procedures, psychotherapeutic treatment, other treatments and medications, pathologic and radiological evaluations 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 Rapid Med.

**RELEASE AND USE OF PATIENT INFORMATION:** I authorize the release of my records, information, treatment and advice, and specific health information:

- (1) AN EMPLOYER who requests services (including history, physical, laboratory and diagnostic tests, and screening for the presence of drugs, alcohol or marijuana)
- (2) INSURANCE COMPANY or other third party payer and their agents as well as any review organization of government agency for the purpose of determining eligibility, available benefits and obtaining payment for services provided.
- (3) EDUCATIONAL OR SCIENTIFIC INSTITUTIONS authorized health care 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 Rapid Med, their agents and allied health professionals; to another health care 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.

I understand this information concerning medical care, advice or treatment may include history and physical/diagnosis/laboratory and diagnostic testing/specific 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.

**ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT GUARANTEE:** In consideration of services provided by Rapid Med, I hereby assign and transfer to Rapid Med any and all rights, which I have against insurance companies, governmental agencies, or third party payers, for payment of charges for services provided by Rapid Med 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 of third party payers. In consideration of services to be provided, I agree to pay Rapid Med in accordance with the regular rate and terms of Rapid Med. I further agree to pay the account in full upon receipt of my statement unless payment arrangements are made with Rapid Med. I authorize said payments to be applied to any unpaid Rapid Med balance for which I am responsible. If any account is placed with a collection agency, an additional 25% will be added to my balance.

I give consent, authorize release, and assigned benefits to Rapid Med: \_\_\_\_\_  
Patient/Guarantor Signature

I GIVE MY CONSENT FOR RAPID MED TO LEAVE A DETAILED MESSAGE ON THE FOLLOWING PHONE NUMBERS:

\_\_\_\_\_

The following people are permitted to request information about me: \_\_\_\_\_

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

**RECEIPT OF HIPAA PRIVACY NOTICE:** I ACKNOWLEDGE RECEIPT OF THE Notice of Privacy Rights with detailed information about how Rapid Med may use and disclose my protected health information. I understand that Rapid Med 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, Parent or Guardian \_\_\_\_\_

Office use only: (to be completed only when a patient declines to sign acknowledgment): \_\_\_\_\_ check here if patient declined to sign acknowledgment \_\_\_\_\_ Staff initials \_\_\_\_\_ Date \_\_\_\_\_