Ph#:

Email:

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Mrkg:

Somerset Valley Urgent Care

Reviewed (Initial)	Mgr Review (Initial)

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⌦ ANNUAL CONSENT, ASSIGNMENT, AND RELEASE FORM INSTRUCTIONS:

Please review **BOTH** sides of this document. Carefully read and initial each of the six (6) sections and sign the reverse side. For your convenience, this document will remain in force for one (1) year from the date signed unless you specify otherwise.

Initial

1

SECTION 1: 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 (or my child's) 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 Somerset Valley Urgent Care, LLC (SVUC).

Initial

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SECTION 2: Release and Use of Patient Information

I authorize the release of my (or my child's) medical records, treatment and advice, and specific health information to:

1. TREATING PHYSICIANS on staff at Somerset Valley Urgent Care, LLC (SVUC), 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 (or my child's) treatment could be adversely affected; and/or
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; and/or
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; and/or
4. AN EMPLOYER who requests services (including history, physical, laboratory and diagnostic tests, and screening for the presence of drugs, alcohol or marijuana).

I understand this information concerning medical care, advice, 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 request SVUC to fax a Visit Summary Report to the below medical provider, or; ❑ please do not send a fax report.

P

Name of PCP/PMD to Receive a Report	City / Township of MD Office	Phone Number

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Initial

3

SECTION 3: Payment Guarantee and/or Assignment of Insurance / Medicare Benefits

In consideration of services provided by Somerset Valley Urgent Care, LLC (SVUC), I hereby assign and transfer to SVUC any and all rights, which I have against insurance companies, governmental agencies, or third-party payers, for payment of charges for services provided by SVUC 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 SVUC in accordance with the regular rates and terms of SVUC. I further agree to pay the account in full upon receipt of my billing statement unless payment arrangements are made with SVUC. I authorize said payments to be applied to any unpaid SVUC balance for which I am responsible. If my account is placed with a collection agency, an additional 35% will be added to my balance.

PLEASE CONTINUE TO REVERSE SIDE & SIGN

Initial

4

SECTION 4: Receipt of HIPAA Privacy Notice

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how Somerset Valley Urgent Care, LLC may use/disclose my (or my child's) protected health information. I understand that Somerset Valley Urgent Care, LLC reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

Initial

5a

SECTION 5: Authorization to Release Medical Information to Family Members or Other Individuals

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996 (HIPAA), in order for your physician or the staff of Somerset Valley Urgent Care, LLC to give copies of and/or discuss your (or your child's) condition/exams/procedures/x-rays with members of your (or my child's) 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 authorization due to the severity of your (or your child's) medical condition, the law stipulates that these rules may be waived.

I authorize Somerset Valley Urgent Care, LLC to release any and all information (including verbal information, medical paperwork, and copies of x-rays) concerning my (or my child's) medical care to the following individuals:

Name (please print)	❑Spouse ❑Parent ❑Child ❑Other: Relationship	Phone Number
Name (please print)	❑Parent ❑Employer ❑Other: Relationship	Phone Number

OR, by checking this box, ❑ I am indicating that I **DO NOT** authorize Somerset Valley Urgent Care, LLC to release any information concerning my care to any individual.

Initial

5b

I authorize Somerset Valley Urgent Care, LLC to leave a message with **DETAILED MEDICAL INFORMATION** and/or test results on the answering machine or voicemail at the following **PHONE NUMBER**: _____ C H

OR, by checking this box, ❑ I am indicating that I **DO NOT** authorize Somerset Valley Urgent Care, LLC to leave a detailed message on my answering machine or voicemail. I acknowledge that by choosing this option that I, the patient or parent, assume full responsibility for contacting Somerset Valley Urgent Care, LLC for the results of all testing.

Initial

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SECTION 6: Authorization to Discuss Financial Information (Cross out and initial if not applicable)

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 you designate other than insurance companies or third-party payers and their agents.

I authorize Somerset Valley Urgent Care, LLC to verbally discuss financial information with: ❑ Same as Section 5a above.

Name of Primary Insured (please print) ❑Self	❑Spouse ❑Parent ❑Other: Relationship DOB: / /	Phone Number
Name (please print)	Relationship	Phone Number

Sign

I acknowledge reviewing, and I understand each of the six (6) detailed sections that I initialed (above) on this *Consent, Assignment, and Release Form.* I understand this document will remain in force for one (1) year from the date signed unless I specify otherwise: ❑ **ONLY USE THIS FORM FOR TODAY'S VISIT**

❑ Minor Child

X Signature of Patient or Parent/Guardian	Patient Name / Relationship (please print) ❑Self	Completion Date
X RENEWAL ONLY Signature of Patient or Parent/Guardian	RENEWAL ONLY Patient Name / Relationship (please print) ❑Self	RENEWAL Renewal Date (1/21)