SAND CANYON URGENT CARE

PRINT PATIENT NAME:_____ **DATE OF BIRTH**_____

REASON FOR TODAY'S _____

CONSENT FOR TREATMENT
RELEASE OF INFORMATION
PAYMENT AUTHORIZATION
DISCLOSURE STATEMENT

The signature of the responsible party listed below hereby acknowledges and agrees to the following:

1. **The physician on duty may examine and treat the patient in accordance with the standard of care in the community; and,**

2. **The patient's medical records can be released to the patient's medical insurance carrier, in compliance with HIPAA, as needed to process the physician's bill; and,**

3. **The insurance carrier will be directed to pay Sand Canyon Urgent Care Medical Center (SCUCMC) directly; and,**

4. **The responsible party accepts liability for knowing and understanding the patient's insurance coverage; and may be billed for any services deemed non covered by your insurance.**

5. **The responsible party agrees to pay any balance due after the insurance company processes the claim, within thirty (30) days of notice from our billing service, regardless of the reason for the balance due (for example, deductible amounts, co-insurance, or denial of benefits by the insurance carrier); and,**

6. **The responsible party agrees that if any balance due SCUCMC is not paid in a timely manner, then attorneys' fees, collection agency costs and any related fees to SCUCMC will be added to the balance due; and,**

7. **The responsible party acknowledges that, in accordance with California law (see below), we are hereby disclosing that the patient may have x-rays and/or laboratory services performed at Sand Canyon Urgent Care Medical Center, and that we have a financial interest in these services, and that the responsible party has the right to chose to have these tests done elsewhere, if desired.**

California Business & Professions Code Sections 650.02(f), 654.2 and 4051.2, and California Labor Code Section 139.3, require a written disclosure of financial interest by a Medical Office which performs X-rays and/or Laboratory Services. Said disclosure must indicate the financial interest of the office, as well as the patient's right to have the services performed elsewhere if the patient so desires.

_____ _____

DATE TODAY **RESPONSIBLE PARTY'S PRINTED NAME**

_____

RESPONSIBLE PARTY'S SIGNATURE