TRUECARE URGENT CARE

# ACKNOWLEDGEMENT AUTHORIZATION & WAIVERS

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. If terms of our Notice change, a revised copy will be made available to you. By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

_____ _____

Print Name of Patient Date

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individuals you authorize our office to discuss care with.

**I give you permission to share my health information with:**

1. Name _____ Relationship _____ Phone_____

2. Name _____ Relationship _____ Phone_____

## Consent to email or text for appointment reminders and other healthcare communication.

If you approve, we may contact you via email and/or text messaging to remind you of an appointment or provide general health reminders or information. I understand that once I have consented to receive communications via text or email, I still have the right to revoke the consent at any time.

**The CELL PHONE NUMBER I authorize** to receive confidential text messages for appointment reminders and general health information is;

_____ *Please initial* _____

**The EMAIL ADDRESS that I authorize** to receive confidential email messages for appointment reminders and general health information is;

_____ *Please initial* _____

_____ I **decline** to receiove communications via **text**.

OR

_____ I **decline** to receive communictions via **email**.

**Revocation** – Use this area to document revocation of a previous form of communication.

_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via text.
_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via email.

Patient signature_____ Date requested: _____

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PATIENT RIGHTS

TrueCare Urgent Care reserves the right to modify the Patient Rights as State and Federal laws require. I have acknowledge receiving a written copy of the Patient Rights and understand my rights.

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

TrueCare Urgent Care reserves the right to modify the privacy practices outlined in the Notice of Privacy Practices. I have received a copy of the Notice of Privacy Practices for the patient outlined above. These authorizations, acknowledgements and waivers cover all services rendered to the above patient for today and all future dates of service. You may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any events that occurred before you notified us of your decision to revoke.

## AUTHORIZATION TO TREAT AND BILL

I give consent for the above named patient to be treated by TrueCare Urgent Care and my credit card wit h signat ure to be kept on file for any balance due aft er insurance adjust ment s are made. The credit card given will be kept on file for 90 days aft er each visit . I authorize the release of any medical and demographic information necessary to process all claims. I authorize payment of medical benefits to TrueCare Urgent Care for all services performed and billed by TrueCare Urgent Care. TrueCare Urgent Care will submit a claim for services rendered to my insurance carrier and they do so as a courtesy. I understand that if I do not provide complete and accurate billing/insurance information at the time of service and this prevents TrueCare Urgent Care from collecting from my insurance company, I will be responsible for the full charges. I understand I will be held responsible for any balance that remains on the account after 45 days or after the insurance company has paid according to contract, which ever comes first. I understand that if any account remains unpaid, it may be sent to collections and collection costs will be added to the account balance and become my responsibility. I understand that any returned checks will have a fee of $25.00 added to the invoice. TrueCare Urgent Care, Inc. reserves the right to refuse care per our company policy.

## WAIVER FOR OUTSIDE LABORATORY SERVICES

It is my understanding that TrueCare Urgent Care may send lab specimens to an outside laboratory . I give permission for those outside laboratories to bill my insurance for their services. I understand that I may incur additional charges as a result of those outside laboratory tests. I understand that TrueCare Urgent Care is not responsible for payment to those laboratories.

## WAIVER FOR NON-COVERED SERVICES

It is my understanding that my insurance company may deem some or all of my visit to TrueCare Urgent Care as a non- covered service making me responsible for payment of all charges for these services.

## WAIVER FOR NON-CONTRACTED SERVICES

It is my understanding that TrueCare Urgent Care may not be contracted with my insurance plan, making me responsible for payment of all charges for these services.

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I understand and agree to abide by these practices and policies as set forth on these pages. These authorizations, acknowledgements and waivers cover all services rendered to the above patient for today and all future dates of service. You may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any events that occurred before you notified us of your decision to revoke.

Patients Signature: _____

_____ Name of Patient Representative Signing for Patient

_____ Relationship of Patient Representative to Patient