



PRIORITY URGENT CARE - Consent, Release and Assignment

CONSENT FOR MEDICAL TREATMENT: I voluntarily present for treatment and consent to my physician and whomever they may designate, associate, treating physician, physician assistant and patient care staff to provide my care. Such care may include, but not be limited to diagnostic procedures, treatment and medications, pathologic and radiologic 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 Priority Urgent Care.

RELEASE AND USE OF PATIENT INFORMATION: 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, alcohol or marijuana or in the case of work-related injuries. 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) TREATING PHYSICIANS on staff at Priority Urgent Care, their agents and allied health professionals; to another health care facility upon direct transfer or referral, primary care physician, provided the physician's name is listed on my registration form. I understand that if I refuse to authorize access to my records for coordination of care, my treatment, outcomes and continuum of care could be adversely affected. I understand this information is concerning medical care, advice or treatment may include history and physical, diagnoses, laboratory and diagnostic testing, specific information concerning substance use/abuse, mental health, human immunodeficiency virus (HIV), hepatitis or other infectious disease(s). I understand that I have the right to revoke this authorization and must do so in writing. If my revocation prevents or reduces payment for services received, I understand that I become responsible for payment.

ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT GUARANTEE: In consideration of services provided by Priority Urgent Care, I hereby assign and transfer to Priority 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 Priority 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 Priority Urgent Care in accordance with the regular rates and terms of Priority Urgent Care. I further agree to pay the account in full upon receipt of my billing statement unless payment arrangements are made with Priority Urgent Care. I authorize said payments to be applied to any unpaid Priority Urgent Care balance for which I am responsible. I agree to pay all costs of collections, including reasonable attorney fees, on all past due amounts. I further give permission to pull a credit report as needed should my account be turned over to an outside source for collection efforts. I understand that any checks returned by my financial institution will incur a \$35.00 returned check fee. I understand that as a contractual obligation with insurance companies, all copays are due at the time of services. I understand that a \$15.00 administration fee will be added to my account if I do not pay my copay at the time of service. I give consent, authorize release



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and assign benefits to Priority Urgent Care. I expressly consent and agree that in order to discuss or service accounts (the Accounts) or to collect amounts I may owe, Priority Urgent Care and its officers, agents, affiliates, employees and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively "you") may contact me by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to me. I expressly consent and agree that you may also contact me by sending text messages and emails using any email address I provide to you or by pre-recorded or artificial voice or voice messages, automatic dialing method systems or devices and pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether I incur charges as a result. ***I consent for Priority Urgent Care to communicate via email, text, SMS, telephone for my care appointment related messages and occasional promotional messages, text and phone data rates may apply.***

PATIENT RECEIPT OF HIPAA PRIVACY NOTICE: Priority Urgent care is committed to maintaining the integrity of your protected health information and complies with all applicable State and Federal regulations. The Federal Privacy regulations of the Health Insurance Portability and Accountability Act [HIPAA] effective 4/14/03. In support of our policy of complying with all applicable regulations, Priority Urgent Care provides patients with the HIPAA Notice of Privacy Rights. While not required in order to receive treatment at Priority Urgent Care, we are obligated under federal regulations to ask that you sign an acknowledgement of the HIPAA Privacy Notice being made available to you. Receipt of HIPAA Privacy Notice: I acknowledge receipt of the Notice of Privacy Rights with detailed information about how Priority Urgent Care may use and disclose my protected health information. I understand that Priority Urgent Care reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

Print Name	
Signature of Patient/Guarantor	Date