Consent for Treatment ~ Financial Policy ~ Consent to Discuss Treatment or Payment for Treatment ~ Notice of Privacy Practice

Patient Name: _____

DOB: _____**Acct #:**_____

CONSENT FOR TREATMENT:

I voluntarily consent to medical treatment as deemed necessary and appropriate by the physicians and staff of Black Hills Urgent Care, LLC participating in my care. With my consent, Black Hills Urgent Care, LLC may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations. Please refer to the Black Hills Urgent Care, LLC's Notice of Privacy Practices for a more complete description of such uses and disclosures. I understand that I may also elect to receive messages with detailed information relating to my medical care. I authorize Black Hills Urgent Care, LLC to leave detailed messages related to my medical care for me via: ☐Phone ☐ Text ☐ E-Mail

FINANCIAL POLICY:

Uninsured: We will collect payment in full for your visit today. Prior to seeing one of our providers we require a down payment of your estimated visit cost. The required amount of the down payment will be given to you by the receptionist as part of the registration process. We accept cash, check, credit/debit card. In addition to the down payment, you may be charged an additional amount when you check-out. For example if you have laboratory tests, x-rays, procedures, injections and/or opt to utilize our on-site prescription services you will be required to pay in full for those additional services at the completion of your visit. By signing below, you agree to pay Black Hills Urgent Care, LLC in full today for the services you receive.

Insured: We will attempt to obtain an estimate of your insurance benefits from your insurance carrier at the time of service in order to determine your payment today. We will file a claim to your insurance carrier. If you have an office visit co-payment amount we will collect the co-payment from you before your visit. Even with an office visit co-pay type of plan your insurance may not cover certain services such as laboratory tests, immunizations, x-rays, injectable medicines/antibiotics, orthopedic supplies, surgical procedures and other services. If your insurance indicates that you owe more than the office co-pay amount we will bill you for these services after your insurance had processed and paid your claim.

For patients with a deductible type plan we will require payment today if your deductible has not been met, as well as applicable coinsurance. Deductibles vary and depend on your specific plan type. Insurance doesn't pay any portion of the bill until your deductible is met. You may be eligible for a refund should your insurance make payment on the claim. We will promptly refund you if this occurs.

Workers Compensation: In the event that you seek treatment today for illness/injury related to a third party, other than Workers Compensation, who may be liable for your medical expenses (such as Motor Vehicle Insurance or Home Owners Insurance) please be advised that it is your responsibility to provide Black Hills Urgent Care, LLC with the appropriate insurance and claims filing information necessary to file your medical claim. If you are unable to provide this information and/or if the third party payer should deny your insurance claim you will be billed for the services you incur today and will responsible to remit payment promptly upon receipt of the first statement and/or provide us with your private health insurance information.

****By signing below I authorize Black Hills Urgent Care and its' associates to contact me regarding my financial obligations and/or business office needs, whether that be via mail, phone or cell phone.**

CONSENT TO DISCUSS TREATMENT OR PAYMENT FOR TREATMENT:

I, _____ , hereby give permission to the following person(s) to discuss treatment or payment for treatment:

			Treatment	Payment
Name: _____	Rel: _____	Ph#: _____	☐	☐
Name: _____	Rel: _____	Ph#: _____	☐	☐
Name: _____	Rel: _____	Ph#: _____	☐	☐

This consent can only be revoked by written notification by the patient/patient representative or automatically expires after 1 year.

NOTICE OF PRIVACY PRACTICE:

By signing below I acknowledge that I have been offered/received the Notice of Privacy Practices and that I understand and agree to the above information.

Signature:_____ **Date:** _____

(Patient/Patient Representative)

Printed name of Representative: _____**Relationship to Patient:** _____