Patient Authorization

Patient Name: ____________________________________Date of Birth ____/____/____

Consent to Treat

I hereby authorize Lanier Urgent Care to render medical care to me during my office visit and to fulfill the orders of my physicians; including consultants, associates and assistants of the physician's choice.

Financial Authorization

I am financially responsible for the services provided which are to be paid on the day services are rendered. I further acknowledge that I am the owner/dependent of the insurance policy and that the insurance contract is between myself/policyholder and the insurance carrier. Lanier Urgent Care has no leverage to obtain payment from my insurance carrier. As such, Lanier Urgent Care will appropriately bill my insurance carrier however I will be responsible for all unpaid services due to copays, deductibles, or rejected claims.

Lanier Urgent Care will attempt to verify insurance coverage at the time of service. Benefit and eligibility information obtained may be inaccurate or incomplete and only the final Explanation of Benefits (EOB) sent from the insurance carrier will stand as the final statement of monies owed. I will be billed (or credited) for any outstanding balances (or overcharges) whereupon I am obliged to make payment within 30 days. After 60 days, past due amounts may be charged to my credit card kept on file with Gwinnett Urgent Care. I realize that failure to keep this account current my result in Gwinnett Urgent Care being unable to provide continuing medical services.

Consent to the Use and Release of Medical Information

I authorize Lanier Urgent Care to release medical information pertaining to my diagnosis and/or treatment, laboratory results, medical history, treatment, or any other such related information to:

- My insurance company(ies) or its designated representatives.
- Any person(s) or entities financially responsible for my care or treatment.
- Representative or local, state, or federal agencies in accordance with law.
- Employees or representatives for investigation and defense of any claim or cause of action, actual or potential which may be asserted against Lanier Urgent Care or its employees.

I have been provided with a Notice of Privacy Practices that provides a more complete description or information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail copy of the revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree with the restrictions requested. I understand I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

___________________________________ ______________________________ ____________

Signature of patient/Legal Representative Patient Name (printed) Date

Patient Consent for Disclosure of Protected Health Information

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Lanier Urgent Care** reserves the right to revise its Notice of Privacy Practices at any time.

I acknowledge and agree that **Lanier Urgent Care** and/or vendor including billing and/or collection companies may contact me on the numbers listed below. I further agree that I may be contacted by use of an Automated Telephone Dialing System (ATDS) or prerecorded message. With this consent, **Lanier Urgent Care** may share my Personal Health Information (PHI) in the following methods:

Leave a message on cell/home phone? YES / NO ____
Phone Number

I authorize **Lanier Urgent Care** to release/disclose my PHI including lab and test results, diagnosis and treatments to the following individuals:

________________________________ ____________________ ___________________
Name Relationship Phone Number

Update Demographics:

Last Name:	First Name:	DOB:	M / F
Street Address:	City:	State:	Zip:
Cell/Home Phone:			

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Gwinnett Urgent Care or insurance company to release any information required to process my claims.

Patient/Guardian Signature. **Date:**