Consent for Admissions: I request and consent to admission to the Katy Urgent Care Center

Consent to Medical Care: I request and consent to treatment as deemed necessary by the healthcare provider which may include lab, x-ray, and other procedures. The provider I see may be an owner of the Facility.

Thank you for choosing the Katy Urgent Care Center. Our main concern is that you receive high quality care. In order to prevent any misunderstanding and to serve you better, we ask that all patients read and understand our financial policy. If you have any questions or concerns about our financial policies, please do not hesitate to ask. Please remember that all charges are your responsibility regardless of whether or not your insurance pays.

Release of Information: I authorize the Katy Urgent Care Center to release any medical or financial information to medical care provider who is performing medical care or a diagnostic test(s) on behalf of; or at the request of the healthcare provider of the Urgent Care Center. I authorize the Urgent Care Center, its agencies and designees, to utilize any information in my medical record for quality assurance and risk management activities. **By state law,** you must be advised that the information authorized for release may include records, which may indicate the presence of a communicable, or venereal disease, which include, but is not limited to disease such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Symptoms (AIDS). I hereby authorize Katy Urgent Care Center to release medical information obtained in the course of my evaluation and treatment to my employer and/or employer's representative in the case of job related injury/illness; primary care physician, and insurance carrier.

Have you received a Copy of the Bill of Rights? ☐ Yes ☐ No

Have you received a Copy of the Privacy Notice? ☐ Yes ☐ No

Payment for Medical Care: I agree to payment for the medical care I receive from the Urgent Care Center, its employees, agents, designees, or independent contractors. I guarantee full payment for all charges by the Katy Urgent Care Center or by other providers of medical care, for such care, subject only to restrictions imposed by the Medicare or State Medicaid Programs, or by any third party payor (for example, an insurance carrier or health maintenance organization (HMC) with which Urgent Care Center has specifically entered into an agreement for payment of medical care provided by the Urgent Care Center or by its employees, agents, designees or independent contractors).

ASSIGNMENTS OF BENEFITS: I hereby authorize and assign payment to the Urgent Care Center of any type of reimbursement or payment from Medicare or State Medicaid programs or other third party payor, for any and all cost of my medical care provided at the Urgent Care Center or by its agents, designees, or independent medical contractors. Further, I understand that **Radiology** and some **Laboratory Services** will bill me separately and assign my insurance benefits to them if their services are rendered during my treatment. I also authorize them to release my medical information needed to my insurance carrier to process the claim.

Insurance Precertification: I understand that Katy Urgent Care Center will attempt, but is NOT ALWAYS able, to verify my insurance benefits. A co-payment will be collected according to my insurance. If unable to verify co-pay amount an estimated co-pay may be collected. The claim will be filed and submitted to the corresponding insurance electronically, but I understand there is a possibility that I could still get a bill depending on my insurance plan and/or deductible. I understand that I am and will be solely responsible for all charges incurred during my visit.

Self-Pay or Uninsured Individuals: Payment is due at the time service is rendered. A fee of $135 is due at the time of registration to see the healthcare provider. Any additional services that may be required will incur additional charges. You will be informed of the amount of these additional charges and e asked to pay for treatment prior to receiving treatment.

Returned Checks will incur a $25 fee. The amount of the check plus the fee must be paid within 10 days of notification by money order, cash or credit card to prevent further action. If a second check is retuned on your accounts we will no longer be able to accept your personnel checks as payment.

I have reviewed this Admission Agreement and fully understand its contents and implications. I agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies paid, including court cost, collection agency fees, and attorney fees.

Signature of Patient Date/Time Please Print Name of Patient

Signature of Guardian/Guarantor, Relationship to Patient ☐ Parent ☐ Guardian ☐ Other _____Please Print Name

Signature of Witness Date/Time Please Print Name of Witness

If Legal Guardian or Other Legal Representative for the Patient, please provide your age and relationship to the patient, and the reason why the Patient is incompetent or unable to sign. If an emancipated minor, please state whether you have lawfully married or a parent or legal guardian of a child.