

Batesville Urgent Care/Greensburg Urgent Care
(To be referred to throughout this form as BUC and GUC)

1. **Consent to Care:** I (We) request and consent to medical, surgical care, tests, procedures, medications and supplies provided by BUC/GUC as prescribed by the attending physician(s), or physician assistant(s), or medical assistant(s). These may include, but are not limited to pathology, radiology, laboratory, and other special services and tests. No representations, warranties nor guarantees as to results have been made to nor relied upon by me (us).
2. **Consent to treatment provided by physician and/or physician assistant or nurse practitioner (PA/NP):** A physician's assistant/Nurse practitioner is a licensed healthcare professional who practices medicine with physician supervision. Physician assistants and/or Nurse practitioners are highly skilled professionals educated to use the same medical treat illnesses, order and interpret laboratory tests, perform minor surgery, and coordinate medical treatment.
3. **Medicaid:** All Medicaid patients are responsible for notifying providers of Medicaid coverage. I (We) are responsible for any spend down payments.
4. **Medicare:** I (We) request payment of authorized Medicare benefits, if applicable, be made on my behalf for any services furnished me by BUC/GUC including physician services. I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid Services and its agents any information that will determine those benefits or benefits for related services.
5. **No appointment necessary:** No appointment necessary refers to only new patients, established patients may be required to schedule an appointment. Some insurance companies may require an appointment because they require additional services and data collection.
6. **Information Release:** I (We) authorize you to release information from or to provide copies thereof of my medical records or non-medical records to Medicare, Medicaid, insurance companies, my employer or to other third party payors reimbursement programs for this visit. I (We) also authorize the furnishing of such information or copies thereof to other hospitals or health care facilities to which I may be transferred, or to physicians attending me and to my family physician, and authorize and direct them to provide such information or copies to you unless otherwise directed in writing.
7. **Deposits:** I (we) understand that a deposit is required at every visit prior to being seen for patients without proof of insurance and those patients with history of past due balances.
8. **Patient balance:** If I (we) have an outstanding patient balance, I (we) AGREE TO PAY THAT BALANCE PRIOR TO BEING SEEN. I (we) agree that if payment can not be made I may request that emergency care be provided to stabilize an emergency condition until transportation can be arranged to an emergency department, or an appropriate referral can be made.
9. **Primary Care:** I (we) understand that BUC/GUC provides care intended to supplement, but not replace care provided by my family physician. BUC/GUC encourages me to establish care with a family physician.
10. **Financial Arrangements:** In consideration of the services to be provided by you, I (We), jointly and severally agree to be responsible for payment for all charges incurred for your services on the date of service unless prior arrangements have been specifically made including all deductibles and charges not covered by insurance. All accounts not paid within 30 days from billing statement will be charged an interest rate of 1 ½ percent per month (18% per annum) or a \$2.00 minimum charge. In the event the account becomes past due, a forty (40%) percent fee may be accessed for collection costs. Accounts not paid within 60 days of date of service are considered past due. In the event litigation is commenced, I (we) agree that I (we) will also be responsible for court costs and reasonable attorney fees. I (We) assign to BUC/GUC and the attending physician(s) all benefits payable by such third-party payors or programs with the understanding that any amount actually collected by you shall be credited against the charges for your service.
11. **Returned Checks:** I (We) understand that I (We) will be charged for returned checks. BUC/GUC will charge a service fee of \$27.50 or 5 % of check value (but not more than \$250) for returned checks. Interest will begin to accrue immediately at 18 % per annum.
12. **Lab work:** We provide several in house lab tests that we bill for at your visit, but at times the physician may order testing that needs to be sent to a lab. THIS WILL RESULT IN A BILL FROM THAT FACILITY.
13. **Valuables:** I (We) further understand that BUC/GUC is not responsible for loss or damage to any such money, jewelry or other valuables. NO EMPLOYEE HAS AUTHORITY TO WAIVE THIS POLICY.
14. **Pre-Certification:** If the insurance company or other third-party payor requires pre-certification, I (the patient) understand that I (We) are responsible for obtaining pre-certification and that I (the patient) will be responsible to BUC/GUC for any amount not paid by the insurance company or third-party payor.
15. **Network Insurance:** BUC/GUC will attempt to bill insurance companies. I understand it is my (the patient) responsibility to check with my insurance company to verify if BUC/GUC is in my network.
16. **Coordination of Benefits:** I (We) hereby authorize third party payors to obtain all information regarding me (the patient) in the possession of the intermediaries administrating benefits under Title XVII of the Social Security Act or other federal or state programs and use such information in determining benefits due for this service. It is further agreed that any credit balance resulting from payment of the insurance or any other sources may be applied to any other account owed to BUC/GUC by the insured of his/her family.
17. **Privacy Notice:** My signature below indicates that I have received a copy of the Privacy Notice and/or have been offered a copy.
18. **Physical Therapy/Nerve Conduction Studies:** I (we) understand that there will be additional charges for which I/(we) am responsible for missed physical therapy appointments.

The undersigned hereby certify that I (we) have read the foregoing, and I the patient, or duly authorized by the patient as patient's general agent acknowledge and accept the above terms. The information given is true and correct to the best of our knowledge and belief. All guarantors certify that they have read the foregoing by signing this agreement.

Signature of Patient (If 18 years or older and appropriate)

Date

Signature of Patient's Parent or , guarantor

Date