WORKPLACE
HEALTH SERVICES

WORKPLACE HEALTH SERVICES
CONSENT FOR TREATMENT AND PATIENT AUTHORIZATION

Date:__________________________ Time:____________ ☐ am ☐ pm

Authorization For Treatment: I have a condition I feel is requiring medical care. I hereby consent to the rendering of such care that may include routine diagnostic procedures, testing, x-rays and such medical treatment the provider considers to be necessary.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantee or warranties have been made to me as a result of treatments or examination at WorkPlace Health Services.

Assignment of Insurance Benefits: I authorize payment directly to this urgent care center for all benefits otherwise payable to me.

Guarantee of Payment: I understand that I am financially responsible and agree to pay all of the charges that are not paid by insurance or any other third party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance co pays, coinsurances, and deductibles today. If you are unable to verify my insurance at time of service, I will pay in full for all services.

I agree that in consideration of the service to be rendered to me that I am obligated to pay the account at WorkPlace Health Services in accordance with the regular rates and terms. Should the account be referred for collection, the undersigned shall pay reasonable attorney's fees and collection expenses incurred by WorkPlace Health Services.

Release of Records: I authorize this urgent care center to release (verbal or in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or other health center operations which may be liable to me or my practitioner(s) for charges for this treatment and for quality management, utilization review, transfer, and follow up purposes.

I realize that among those who attend patients at WorkPlace Health Services are medical, nursing and other health care students, who unless requested otherwise, may be present during patient care to observe and participate in my diagnosis and care as a part of their education.

Receipt of Privacy Practices: I acknowledge that I have received and read the Notice of Privacy Practices of this urgent care center and have had the opportunity to ask questions. I certify that I understand this form and its consent.

Reason for visit today____

AUTHORIZATION:
Patient Signature:____________________________________ Date:________________

Patient Representative Signature_________________________ Date: ________________
Relationship: ☐ Parent ☐ Court Appointed Guardian ☐ Healthcare Representative/Power of Attorney ☐ Other__________

I authorize results, referral information or questions regarding my medical care to be left on my answering machine or voice mail at the following number(s)______________________________

Patient Signature____