AccuDoc Inc. PC dba AccuDoc Urgent Care (to be referred to throughout this form as AUC)
Assignment of benefit/consent for treatment/ financial responsibility/release of records

1. CONSENT TO CARE: I (we) request and consent to medical, surgical care, tests, procedures, medications and supplies provided by AUC as prescribed by the attending physician or physician(s) assistant. These may include, but are not limited to pathology, radiology, laboratory, 1-on-1 natural medicine web consultations 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. MEDICARE: I (we) request payment of authorized Medicare benefits be made on my behalf for any services furnished to me by AUC including physician services. I authorize medical or other information be released to the Center of Medicare Services and its agents any information that will determine those benefits or benefits for related services.
4. INFORMATION RELEASE : I (we) authorize you to release information from or to provide copies of my medical records or non-medical records to all insurance companies, my employer or to other third party payors reimbursement programs for any visits at this facility. I also authorize the furnishing of such information or copies thereof to other hospitals or health care facilities to which I may be transferred to or to physicians attending me. AUC also has my permission to request/obtain my medical records from physicians or facilities for treatment, unless otherwise directed in writing.
5. PATIENT BALANCE: If I (we) have an outstanding patient balance, I (we) AGREE TO PAY THAT BALANCE PRIOR TO BEING SEEN
6. PRIMARY CARE: I (we) understand that AUC provides care intended to supplement, but not replace care provided by my family physician. This applies to Natural Medicine Consultations as well. AUC providers do not take call after hours, nor hold hospital privileges. AUC encourages me to establish care with a family physician.
7. FINANCIAL ARRANGEMENTS: In consideration of the services to be provided to 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. In the event the account becomes past due, a 37% 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 AUC 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 services.
8. RETURNED CHECKS: I (we) understand that I (we) will be charged $20.00 on all returned checks (Indiana). Our Ohio location will charge $30 if check amount is < or = to $300 OR 10% of check amount if > $300.
9. LAB WORK: We provide several in house lab tests that we bill for at your appointment but at times the provider may order testing that needs to be sent to a lab. THIS WILL RESULT IN A BILL FROM THAT FACILITY.
10. VALUABLES: I (we) understand that AUC is not responsible for loss or damage to any money, jewelry or other valuables. NO EMPLOYEE HAS THE AUTHORITY TO WAIVE THIS POLICY.
11. 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 AUC for any amount not paid by the insurance company or third-party payor.
12. NETWORK INSURANCE: AUC will attempt to bill insurance companies. I understand it is my (the patient) responsibility to check with my insurance company to verify if AUC is in my network.
13. 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 if 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 if the insurance or any other sources may be applied to any other account owed to AUC by the insured of his/her family.
14. ADDITIONAL FEES: I (we) understand that AUC charges a fee for services performed in an urgent care facility and during evening, weekend & holiday hours.
15. CREDIT CARD POLICY: I (we) authorize AUC to charge any and all outstanding balances, after insurance company reimbursement or denial, up to $300 to my credit/debit card on file. I understand that I will not receive a statement if there is no balance due after processing my credit card for payment.
16. PRIVACY NOTICE: My signature below indicates that I have received a copy of the Privacy Notice and/or have been offered a copy.
17. PHYSICAL THERAPY CANCELLATION POLICY: I am aware that a 48 notice is required for a physical therapy appointment cancellation/reschedule. If the scheduled appointment is missed or cancelled (outside the 48 hours), I authorize AUC to bill my credit card on file $25.00 for each cancellation and/or no show.
18. NON-DISPARAGEMENT: I (we) agree to take no action which is intended, or would reasonably be expected, to harm the reputation of AUC or which would reasonably be expected to lead to unwanted or unfavorable publicity to the Company, including disparaging comments tor reviews on social media. I (we) agree that failure to adhere to this non-disparagement clause will result in liquidated damages of $800 per day for each day of violation of this clause.

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.

_____ _____
Patient if 18 years or older date

_____ _____
Patients legal guardian, Representative,(guarantor) date

IN CASE OF EMERGENCY

Name and phone number of a local friend or relative (Not living at the same address	Relationship to patient	Home Phone#	Work Phone#

To whom may we release medical and billing information to? _____