America's Express Urgent Care (AEUC) Privacy and Billing Procedures Authorization and Acknowledgement

These authorizations/acknowledgements cover all services rendered to me, or the patient I am signing for, today and all future dates of service. I understand I may revoke this authorization by informing AEUC in writing, but if I do revoke this authorization, it will not affect anything prior to the date the revocation is received by AEUC .

Acknowledgement of Receipt of Notice of Privacy Practices Authorization to Release Information to Family/Friends or Others

I have received a copy of AEUC Notice of Privacy Practices. I authorize AEUC to release any information regarding my treatment; including lab results, x-rays, and medical records, to the following individuals/entities (AEUC may not release information or records to the names individuals/entities unless you identify them here):

Name________________________________ Relationship to Patient____________________

Name________________________________ Relationship to Patient____________________

Name________________________________ Relationship to Patient____________________

Name________________________________ Relationship to Patient____________________

AEUC will use my home phone number and primary address supplied during registration to contact me regarding my treatment; including lab results, x-rays, and medical records. I will ensure this information is up to date at every visit.

Authorization to Treat and Bill

I consent to be treated by AEUC. If I am not the patient being treated, I am authorized to consent to treatment and billing for the patient identified below. I authorize AEUC to bill my medical insurance for the care I receive and to release any information the insurance carrier requires to process this bill. I authorize payment of medical benefits to AEUC, or to outside labs as described below, for all services performed and billed by AEUC. I understand that I am responsible for all charges for the treatment I receive at AEUC. I understand that AEUC providers may utilize the Prescription Monitoring Program service at no additional charge to me.

As a courtesy, AEUC will bill my medical insurance. If I do not provide complete and accurate insurance information to AEUC, I understand AEUC may not receive payment for my carrier and I will be entirely responsible for my bill. Even after my medical insurance company pays AEUC bill, I may owe AEUC payment for services not covered by my insurance and I agree to pay these promptly to AEUC. I understand that AEUC may send lab specimens to an outside laboratory. I authorize any lab performing services for me to bill my medical insurance for their services. I understand that my medical insurance may not pay for all services provided by the lab and I agree to pay any remaining balance promptly to any outside lab providing services to me. I understand that AEUC is not responsible for payment to outside labs for tests provided to me.

To protect my privacy and prevent fraud, I understand that if I cannot provide acceptable photo identification at the time of service, AEUC may choose not to bill insurance and may decline credit/debit cards and checks as a form of payment. I understand that if I fail to pay AEUC for services provided to me, the balance owed may be sent to collection and I may incur additional fees.

Signature ________________________________ Today's Date____________________

Patient Name ________________________________ Patient's date of birth____________________

Name of Patient Representative ____________________ Relationship to Patient____________________

*(Required if the patient is a minor or if the patient is unable to sign this form.)