AGREEMENT TO PAY FOR TREATMENT:

I, the responsible party, hereby agree to pay all the charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization, with which this office had a contractual agreement, I agree to pay all applicable co- payments, co- insurance and deductibles, which arise during the course of treatment for the patient. The responsible party also agrees to pay for treatment rendered to the patient, which is not considered to be a covered service by my insurer and/or a third party insurer or other payer. I further understand that if I do not show for an appointment or do not give 24 hours notice to Tracy Urgent Care when canceling an appointment I may be responsible for the charges up to the potential cost of the visit.

INITIALS ____________________ DATE ____________________

RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO THE PROVIDER:

I, hereby authorize Tracy Urgent Care and its employees to release and disclose, all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges. I, authorize the release and disclosure of any and all of my, or my child's, medical records to any other entity, including, but not limited to specialty physicians, hospitals, or other health care providers which may be of assistance in the opinion of this office, in providing treatment of the patient. I, authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled. I, authorize this office and/or its employees to release, via fax or other secure electronic means, medical records which are needed in order to provide the patient with the most appropriate medical care. I, authorize and request that payment of any third party or insurance company benefits be made directly to Tracy Urgent Care, any services furnished to the patient. The signature furnished below shall suffice for all insurance forms on a continuing basis.

INITIALS ____________________ DATE ____________________

CONSENT FOR TREATMENT:

By signing below, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medical services, surgical or diagnostic procedures, including lab and radiographic studies, as ordered by Tracy Urgent Care and it's healthcare providers.

INITIALS ____________________ DATE ____________________

*Patients with Health Plans, please present your insurance ID Card to the receptionist after completing this form.
*Some contract Health Plans (HMO, PPO, IPA, etc.) require a co- payment at the time of service- Please have this ready prior to your visit as well as any current balance due. If past due balance is not paid at the time of visit, patient may be required to reschedule the appointment. *Patient is responsible for all lab work and must be prepared to tell the TUC staff which lab their insurance requires them to use. If presenting new insurance on the day that labs are drawn, the patient should inform the person drawing their labs. TUC will not be able to make changes to the lab company once the lab leaves our office for processing.

PLEASE PRINT PATIENT'S FULL NAME ____________________ PATIENT'S SIGNATURE ____________________

DATE ____________________ DATE OF BIRTH ____________________