

Patient Name: _____ **Date:** _____

Please read the following information below. Initial each statement that applies. Your signature below applies to the services rendered in conjunction with today's services.

Initial **Medical Records:** I ask Kootenai Urgent Care to furnish all Medical records pertaining to this visit to _____ . I understand that my express consent is required for Kootenai Urgent Care to release information relating to sexually transmitted disease, mental illness and or psychiatric treatment. You are specifically authorized to release to the person or entity above all information or medical records pertaining to this visit. I understand that Kootenai Urgent Care cannot limit or control the subsequent use or dissemination of medical information by the party to whom I request the information be furnished. This is a free and voluntary act by me. I hereby release Kootenai Urgent Care and its staff from legal responsibilities that may arise from the release of the medical information hereby authorized.

Initial **Acknowledgment of Privacy Practices:** I acknowledge and agree that I have received / read and understand Kootenai Urgent Care Notice or Privacy Practices.

Initial **Disclosure of Protected Health Information (PHI) to Family and Friends:** This is to certify that I, the undersigned, authorize Kootenai Urgent Care to disclose Protected Health Information (PHI) to family members and friends. Please identify individual(s) and relationship(s) [include spouse, grandparents, step-parents, etc.]:

Disclosure of PHI to family and friends will be made in accordance with the procedures set forth by Kootenai Urgent Care policy entitled 'Policy Regarding Disclosure of Health Information to Family Members and Friends'.

Minor Consent: This is to certify that I (we) the undersigned hereby consent to and authorize the release of medical information, including results of x-rays and/or lab specimens pertaining to but not limited to contraception, abortion, blood donation, reportable diseases, and mental illness to my parent or guardian as named above.

Signature of Minor: _____ Printed Name: _____

Initial **Consent for Service:** This is to certify that I (we) the undersigned hereby consent to and authorize the administration and performance of all treatment, including that taking of x-rays and / or lab specimens, which in the judgment of my provider may be considered necessary or advisable. I (we) also acknowledge that Kootenai Urgent Care is an, episodic, outpatient facility, which is not intended, nor able, to provide chronic, comprehensive, prolonged, continuous, nor hospital inpatient care.

Initial **Medicare Authorization:** I request that payment of authorized Medicare benefits be made either to me or on my behalf to Kootenai Urgent Care for any services furnished to me by that physician / supplier. I authorize any holder of medical information about me to release to the Health Care Administration and its agents and information needed to determine these benefits, or the payable for related services.

Initial **Financial Agreement and Assignment:** This is to certify that I (we) the undersigned hereby consent to and authorize the release of information necessary to settle my insurance claim, including worker's compensation, is hereby granted. Authorization for my insurance company to pay all physician benefits directly to Kootenai Urgent Care is hereby granted. It is my responsibility to know and understand my own insurance plan and coverage, and know that having insurance is not a guarantee of benefits. I understand that I am personally financially responsible to Kootenai Urgent Care for all charges not covered by assignment including co-pays, coinsurance, deductible and ineligibility. Payment is required in full at the time of service. If I have been involved in a motor vehicle accident at any capacity, I understand that neither health insurance nor auto insurance will be billed; therefore I am responsible for fees in full at time of service. Checks that are returned will be assessed a \$20.00 NSF fee.

Signature: _____ **Date:** _____
Patient / Parent or Guardian

Parent / Guardian - Printed Name: _____ Relationship: _____