



Agreement for Treatment

General Consent for Treatment: The patient is under the care of his or her physician and hereby consents to and authorizes Statcare Urgent Medical Care to furnish the necessary treatments, procedures, X-Ray exams, laboratory procedures, medications, and supplies to the patient as ordered by the physician or physician's assistant. The patient acknowledges that no guarantee or assurances have been made as to the results of the treatment.

X-Ray Notification: The patient acknowledges that any and all X-Rays taken at this facility are part of the medical record and are property of Statcare Urgent Medical Care. A report of the findings may be obtained upon request. A CD containing the X-Ray film can be purchased for \$15.00.

Release from Liability: The patient releases Statcare Urgent Medical Care from all liability due to the loss or damage to any valuables.

Itemized Statement: The patient has the right to receive an itemized bill upon request by sending a written request to the Statcare Urgent Medical Care Facility or by calling the office at (516)-938-1550.

Notice of Privacy Practices and Patient's Bill of Rights: By signing below the patient acknowledges that he or she has read and signed the HIPPA form and the Statcare Urgent Medical Care's Patient Bill of Rights.

Insurance Authorization: I understand that I am responsible for notification to my insurance company to obtain authorization for services rendered. I understand that if this is not done, insurance benefits may be denied, reduced, and/or terminated.

Assignment of Medicare Benefits: I assign the benefits payable for the physician's services to the Statcare Urgent Medical Care to submit a claim to Medicare/Medicaid for payment.

Patient Agreement: I also agree to the Statcare Urgent Medical Care at the time of treatment the difference between what the insurance company is expected to pay and the estimated charges. I agree that if Statcare Urgent Medical Care has been unable to verify insurance coverage, that I will pay the entire estimated charges at the time of treatment. Should the accounts be referred to a tax collection, I agree to pay all expenses of collection, including attorney/collection agency fees.

Patient Signature

Print Patient Name

Date

Signature of Legal Guardian

Print Name of Legal Guardian