MEDICAL SERVICES AGREEMENT

Patient's Name: _____

1. **MEDICAL CONSENT**: I consent to any medical treatments or procedures which may be performed on an outpatient basis (including emergency treatment or services), which may include but are not limited to medications, injections, taking of medical photographs, laboratory procedures, and/or x-ray examinations provided to me under the general and special instructions of the physicians, staff, or other health care providers of Advanced Urgent Care Center, A Medical Corporation (herein referred to as "AUCC") assisting my care.

2. **FINANCIAL AGREEMENT: I understand that all charges are due at the time of service.** I agree to pay AUCC for all charges for healthcare services and professional services provided to me by physicians and other healthcare professionals. Acceptable forms of payment include Cash, Visa, MasterCard, Discover and Debit card. If I am a non-insured patient, I agree to pay for my visit in full at the time of service. If AUCC is a participating provider with my insurance company I understand that my co-pay, coinsurance, deductible and/or any outstanding balances are due at the time of service. I understand that my insurance policy is a contract between myself and my insurance company; AUCC is not involved. In order for AUCC to file claims and accept payments from my insurance company, I understand that I must present current insurance information at each visit and that AUCC will need to verify my health insurance coverage. In the event that AUCC is not able to verify my insurance eligibility and benefits before my visit, I agree to pay for my visit in full at the time of service. A refund will be issued if my insurance pays for the visit. I also understand that I am financially responsible for any services not covered by my insurance company. When my spouse or a financial guarantor signs this agreement, the spouse or the financial guarantor shall be jointly and individual liable with me. Should my account(s) be referred to an attorney or a collection agency for the collection, the undersigned shall pay the actual attorney's fees (including costs) and collections expenses incurred in addition to the other amounts due. Unpaid accounts referred to outside agencies for collection shall bear interest at the current rate per year from the date of referral.

3. **INSURANCE AUTHORIZATION AND RELEASE:** I request that payment of authorized benefits, including Medicare, and any other government sponsored program, private insurance, and any other health plans be made to AUCC for any services furnished by that provider. To the extent necessary to coordinate my health care or determine liability for payment and to obtain reimbursement for services rendered, I authorize AUCC to disclose portions of or all of my records, including my medical records to any person or corporation which is or may be liable for all or any portion of AUCC's charges, including but not limited to insurance companies, health care service plans, governmental agencies, or worker's compensation carriers. I authorize AUCC to act as my agent to help me obtain any required pre-certification as well as acting as my agent to help me obtain payment from my insurance companies. I authorize my insurance companies to give AUCC any information required to fulfill this function. This will remain in effect until revoked in writing.

4. **RELEASE OF MEDICAL INFORMATION:** I hereby authorize AUCC to release any information in my chart to any practitioner, doctor, hospital, or medical institution to which I may be referred to assist in my care. Additionally, I authorize AUCC to provide a copy of my medical records to my primary care physician (PCP) to allow for continuity of care.

5. **NOTICE OF PRIVACY PRACTICES:** By signing this form, you acknowledge receipt of the "Notice of Privacy Practices" of AUCC. Our "Notice of Privacy Practices" provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Our "Notice of Privacy Practices" is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting AUCC at (909) 981-2273.

6. **IN-HOUSE PHARMACY:** I understand that, for my convenience, AUCC can dispense some prescription medications necessary to treat my medical condition(s). I understand that my insurance will not be billed for medications dispensed and that my pharmacy benefits DO NOT apply to this service. **Any medication(s) dispensed in the office are my responsibility and are an additional charge to my office visit charge.** I also understand that if I prefer to use an outside pharmacy, a prescription can be provided to me at no additional charge.

7. **PERSONAL VALUABLES:** AUCC shall not be liable for the loss of or damage to any money, documents, jewelry, glasses, dentures, furs, or other articles of unusual value and shall not be liable for loss or damage to any personal property.

AUCC and the patient or the patient's representative, hereby enters into this agreement. The undersigned certifies that he/she has read and agree to the foregoing, received a copy thereof, and is the patient, the patient's representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

_____	_____		_____	_____
Signature of Patient	DATE	or	Signature of Patient's Representative	DATE
_____	_____		_____	
Medical Practice's Representative	DATE		Name & Relationship of Representative to Patient	