73015 Hwy 25-Covinton, LA 70435 P: 985-400-5370 F: 985-400-5041

CONSENT FOR TREATMENT & PAYMENT

I, _____, give my signed consent to Total Health Urgent Care to provide clinical services needed by me, including any procedures and treatments deemed necessary for my best health and wellness. I understand that Total Health Urgent Care will explain treatments and procedures to me. I further understand that this consent shall remain in effect until it is retracted by in writing to Total Health Urgent Care. I hereby authorize payment directly to Total Health Urgent Care from all medical benefits available to me including major medical, Medicare, private insurance, workers compensation, and personal injury coverage. I understand that if my insurance coverage does not cover the services rendered, the services will be billed to me directly. A photocopy of this agreement is to be considered as valid as an original authorization. I hereby authorize Total Health Urgent Care to release all information necessary to secure payments.

_____ _____

Patient/Guardian Signature Date

_____

Print Patient/Guardian Name

Notice of Privacy Practices and Policy

If you have any questions about this Notice, please contact:
Total Health Urgent Care P: 985-400-537 Clinic Address: 73015 Hwy 25 Covington, LA 70435

It is the policy of Total Health Urgent Care to provide you with a privacy notice that explains how your healthcare information is being used and disclosed. Total Health Urgent Care is required by law to maintain the privacy of your protected health information and provide a notice of its legal duties and privacy practices with respect to protected health information.

This notice of Privacy Practices describes how Total Health Urgent may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by state or federal law. It also describes your rights to access and control your protected health information. “Protected health information” is information related to your past, present or future physical or mental health or condition and related health care services, including demographics that may identify you.Total Health Urgent Care is required to abide by the terms of this Notice of Privacy Practices currently in effect. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time and will be posted at the Total Health Urgent Care office. Upon your request, we will provide you with a revised Notice of Privacy Practices. You may request a revised Notice of Privacy Practices by calling Total Health Urgent Care at 985-400-5370 and requesting that a revised copy be sent to you in the mail. We retain prior versions of the Notice of Privacy Practices for six (6) years from the revision date.I acknowledge that I have received a copy of Total Health Urgent Care Notice of Privacy Practices. This notice describes how Total Health Urgent Care may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my health information.

_____ _____

(Signature of Patient) Date

Patient Financial Responsibility

Thank you for choosing Total Health Urgent Care for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Copays are due at the time of service.
- Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
  - Charge for returned checks - $__30_____
- You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to pursue the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.
- By my signature below, I hereby authorize assignment of financial benefits directly to Total Health Urgent Care and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Patient Name _____

Patient/Guardian Signature_____

Date_____