

# East Valley Urgent Care

## MEDICAL TREATMENT AND FINANCIAL AGREEMENT

Thank you for choosing East Valley Urgent Care and as your Urgent Care and Rehabilitative provider. We are committed to providing you with quality and affordable medical care. We ask that you read, sign and return this form to us prior to your treatment.

### **CONSENT FOR MEDICAL TREATMENT**

Patient, or patient's legal representative, agrees to the following terms of treatment:

I, the patient or authorized representative, consent to any examination, evaluation and treatment regarding any illness, injury and/or other health concern affecting me at any time I am present at East Valley Urgent Care for treatment. These services may include, but are not limited to, laboratory procedures, x-ray examinations, and medical and/or surgical treatment or procedures.

### **FINANCIAL POLICY**

- All patients must provide to East Valley Urgent Care accurate and complete personal and insurance information prior to being seen by the doctor.
- Payment is required at the time of service and may be in the form of cash, or credit card. If paying by credit card please be aware East Valley Urgent Care accepts Visa, MasterCard, Discover and American Express. Sorry for the inconvenience as we no longer accept checks.
- East Valley Urgent Care may disclose all or part of a patient's medical or financial records (including information related to alcohol and drug abuse, mental health diagnosis and treatment, HIV related or other communicable disease related information) to third parties to obtain payment for services provided to you, the patient.
- We will be glad to file on your behalf a claim with your insurance provider. It is your responsibility to comply with any pre-determination or notification requirements that your insurance provider may require. Many of the services provided by East Valley Urgent Care may be covered and paid for you by your insurance provider. Unfortunately, insurance providers do not pay for all services that East Valley Urgent Care may deem appropriate.
- In all cases we require the guarantor, the person who is financially responsible, to be personally liable for all balances.
- East Valley Urgent Care believes the fees associated with its services are reasonable and customary fees for our region and specialty. If your insurance provider uses a different fee schedule, you may be responsible for any remaining balance(s).
- East Valley Urgent Care may charge reasonable fees for services related to your account including, but not limited to, returned check fees, interest on unpaid accounts and copies of medical records.
- Should East Valley Urgent Care find it necessary to forward an account balance to a collection agency, the guarantor, the person who is financially responsible for all charges incurred from the said agency. If sent to collections due to lack of payment you will be charged a minimum of 45% in addition to the balance owed as well as all other collection fee(s). Once sent to collections we will no longer be able to make payment arrangements it will have to be done through the collection agency assigned to your case.
- Your personal information will be updated at least once yearly to verify the information currently on file is correct.
- East Valley Urgent Care may collect a deposit on the charges you incur today applicable to your balance, (e.g. copay, deductible and/or self pay) and bill you for any remaining balance(s). All bills are due upon receipt.
- Federal laws require that we submit every claim to an insurance company accurately and report the exact services performed and the exact reason for performing them. We will not change any information just so the insurance provider can/will pay a claim.

I understand this medical treatment agreement and financial agreement will be valid for all services provided at East Valley Urgent Care from the date signed forward. I have read and understand the medical treatment and financial agreement and agree to follow the terms as provided within. Also, by signing this form states I have read and received a copy of the Notice of Privacy Practices. I am the patient, the parent of a minor child, or the legally authorized representative of the patient and am duly authorized to act on behalf of the patient and to sign this agreement.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Witness