

CONSENT FOR TREATMENT

I voluntarily present for treatment and consent to the physician and whomever they may designate as their assistant, associate, treating physician and patient care staff to provide my care. Such care may include, but not limited to, diagnostic procedures, psychotherapeutic treatment, other treatment and medications, pathologic and radiological evaluations and procedures considered advisable in my diagnosis, treatment, and course of care. I recognize it is the responsibility of my physician to explain to me the nature of any diagnostic test and medical and/or surgical procedures judged by them to be necessary for my treatment and to advise me of risks and consequences of such procedures. I acknowledge that no guarantees have been made to me as to the result of any treatments, examinations, and/or operative procedures performed at Velocity Care Urgent Treatment Center.

RELEASE OF MEDICAL INFORMATION:

I hereby authorize the physician involved with my care to release information from my medical record as may be required to any person, corporation, or agency which is legally responsible or has good cause to believe is legally responsible for processing and/or paying all or any part of the physician's charges and/or professional fees which incur.

ASSIGNMENT OF BENEFITS:

In consideration of services provided by Velocity Care Urgent Treatment Center, I hereby assign and transfer any and all rights, which I have against insurance companies, governmental agencies, or third party payers, for payment of charges for services provided to me or one of my dependents. I understand that I am responsible for and will pay the portion of my bill not covered in accordance with the regular rates and terms of Velocity Care. I further agree to pay the amount in full upon receipt of my billing statement unless payment arrangements are made. I authorize payments to be applied to any unpaid balance for which I am responsible. If my account is placed with a collection agency, an additional 25% will be added to my balance.

RECEIPT OF HIPPA PRIVACY NOTICE:

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how Velocity Care Urgent Treatment Center may use and disclose my protected health information. I understand that Velocity Care Urgent Treatment Center reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

Patient/Responsible Party Signature

Date