

Mission Statement

99W Urgent Care and Health Center is dedicated to improving the health and well-being of our patients by providing quality health care services and resources in an ethical, personal, efficient and cost effective manner while maintaining the importance of compassion, respect, and dignity.

Financial Agreement

I agree that I will pay 99W Urgent Care and Health Center all charges for services rendered to the patient named below. I understand that laboratory services will be billed separately.

I authorize payment directly to 99W Urgent Care and Health Center of all outpatient benefits otherwise payable to me or for my benefit by reason of any insurance policies. I assign such benefits to 99W Urgent Care and Health Center in an amount not to exceed the charges from the services referred to above.

If any indebtedness for such charges is placed with an attorney for collections, I agree to pay 99W Urgent Care and Health Center such collection costs, including attorney's fees.

Social Security Act (Medicare/Medicaid)

I certify that the information given by me in applying for payment under Title XVII (Medicare) or Title XIX (Medicaid) of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediaries or any carriers and information needed for this or related medical claims. I request that payment of authorized benefits be made on my behalf.

Medicare: **Yes** **No**

Consent for Medical Treatment

I consent, as patient or as the parent or legal guardian of patient, to any out patient services rendered on the instructions of the attending physician.

Release of Information

I authorize 99W Urgent Care and Health Center to release information to my insurance company, with respect to my (or my dependent's) diagnosis or treatment.

If I have been referred by, or am being referred to another physician, I authorize 99W Urgent Care to release my clinical information to this physician for continuing care.

I HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS.

Printed Name of Patient

Signature of Patient or Guarantor

Relationship to Patient

Date