Notice of Practices and Consent to Treat

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
REVIEW IT CAREFULLY.

This practice is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices please contact:

PMC Urgent Care Center
311 Clifty Drive
Madison, IN 47250
812-274-2724

CONSENT FOR TREATMENT

I Hereby Consent for Treatment by the staff of PMC Urgent Care and Release of Benefits and Information.

I authorize my insurance benefits to be paid directly to PMC Urgent Care /treating physician. I understand that I am financially responsible for any balance due. I authorize the physician or insurance company to release any information required for the claims.

PLEASE NOTE: We accept most insurance plans. Should your insurance company deem services not covered, it will be your responsibility to pay for services rendered in full.

*It is the patient's responsibility to obtain any referral needed for treatment. The patient/guardian will be held financially responsible for any visits that do not have an approved referral.

As required by the health insurance portability and accountability act of 1996 this practice my use your health information for the purpose of treatment, payment, or health care operations. You have the right to review this notice. My signature indicates that I have been given the opportunity to read the HIPAA notice of information practices and to have any questions answered before signing. I authorize my email to use for delivery of results.

SIGNATURE____DATE________________________