# PATIENT AUTHORIZATION

Patient Name: _____ Date of Birth ___/___/___

## Consent to Treat

Patient consents to the rendering of Medical Treatment/Services as considered necessary and appropriate by the attending physician or other practitioner, a member of NGUC medical staff. Medical Treatment/Services may be performed by "Healthcare Professionals" (physicians, Physician assistants, nurses, technologist, technicians, or other healthcare professionals). Patient authorizes the attending or other practitioner, the medical staff of NGUC to provide Medical Treatment/ Services ordered or requested by attending or other practitioner and those acting in his or her place. The Treatment/Services includes, but is not limited to: urgent care; examinations (x-ray or otherwise); laboratory procedures; medications; infusions; drugs; supplies; surgical procedures and medical treatments (i.e. Identification, diagnosis, treatment, performance improvement, education, safety, security) and other services which patient may receive. In the event NGUC determines that Patient should provide blood specimens for testing purposes in the interest of the safety of those with whom Patient may come in contact; Patient consent to withdrawing and testing of Patient's blood and to the release of test information where this is deemed appropriate for the safety of others.

## Financial Authorization

I understand it is the responsibility of each patient to arrange for payment for the medical services received in this office. I hereby authorize any insurance benefits to be paid directly to North Georgia Urgent, and recognize my responsibility to pay for all non-covered services, including out of network insurance expenses. An attempt will be made to verify all insurance at the time of service for each visit. I understand that if I have Co-pay or Co-Insurance that the amount is due at the time of my visit. I also authorize the release of any information necessary to process an insurance claim. Charges for all minors are the responsibility of the parent, guardian, or individual presenting the child for treatment.

## Consent to Obtain Medical Records:

I hereby authorize NGUC to obtain medical records from any other physician or medical facility necessary in the course of my treatment.

## Acknowledgment of Privacy Rights:

By signing below I acknowledge that I have received the North Georgia Urgent Care notice of Privacy Practices and Individual Rights.

I acknowledge that I have read the above; I am giving my consent to the above, and have been informed of my rights to privacy.

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Print Patient Name Signature Date