Consent to Treatment/NPP Acknowledgment/Financial Responsibility

Consent to Treatment

I voluntarily consent to receive medical and health care services provided by Armstrong Urgent Care providers, employees and other associates as my providers deem necessary. I understand that such services may include diagnostic procedures, examination and treatment. I understand that this consent to treatment will remain valid and remain in effect as long as I am a patient of Armstrong Urgent Care unless revoked by me.

Release of Medical Information/Notice of Privacy Protections

Your protected health information pertains to your diagnosis and/or treatment at Armstrong Urgent Care, including but not limited to information concerning mental illness, use of alcohol, drugs or communicable diseases such as HIV/AIDS, laboratory test results, medical history, treatment progress or any other such related information. Our notice of privacy practices provides information about how Armstrong Urgent Care may use and/or disclose protected health information about you for treatment, payment, healthcare operations and as otherwise allowed by law. I understand Armstrong Urgent Care cannot be responsible for use of re-disclosure of information by third parties.

Financial Responsibility and Assignment of Benefits

In consideration for receiving medical/health care services, I hereby assign my right, title, and interest in all insurance, Medicare/Medicaid or other third party payer benefits for medical or health care services otherwise payable to Armstrong Urgent Care. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third party payer, up to the total amount of my medical and healthcare charges to Armstrong Urgent Care. I certify that the information I have provided in connection with any application for payment by third party payers including Medicare/Medicaid is correct. I agree to pay all charges for medical and health care services not covered by or which exceed the amount estimated to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third party payer and agree to make payment as requested by Armstrong Urgent Care.

I certify that I have read this form or it has been read to me and I agree to the terms set forth.

Patient's Printed Name

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Signature   Date

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