North Georgia Urgent Care

Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been given a copy of NORTH GEORGIA URGENT CARE Notice of Privacy Practices. The notice contains information regarding potential uses and disclosures of my protected health information (as that term is defined under the Health Insurance Portability and Accountability Act of 1996 "HIPAA")that may be made by the practice, and of my rights and the practice's legal duties with respect to my protected health information. I have had the opportunity to review the notice and take a copy with me if I so choose.

Authorization to Pay Benefits to Physician

I understand that my insurance may send payment for the provider's services to me. I hereby assign to the above named clinic all surgical, medical insurance and/or other benefits, if any otherwise payable to me for their services as described below. I agree to endorse the checks over to the clinic. I understand that if I use the insurance proceeds for my personal use, I have committed fraud. I hereby authorize and direct payment to the above named clinic, unless charges for their services have been paid, so much of any cause of action or right of recovery and any payment proceeds relating thereto, that I may have against my third party whose actions may have caused injury or illness for which I am being treated by the above named clinic.

I further understand that should account with North Georgia Urgent Care become delinquent that I will be turned over to a collection agency; I will be responsible for the 18% interest on my outstanding balance or charges that may be incurred in the collection of my account.

I hereby authorize North Georgia Urgent Care to release any information acquired in the course of my examination or treatment to: Any physician, medical practitioner, hospital, clinic or other medical or medically related facility, or insurance company. I understand that the information released to these facilities will be used in furthering my treatment or processing my claim with my insurance company. The information released will not be given, sold or transferred to any other person not mentioned above. I understand that I am entitled to any photocopy of this authorization upon request.

Consent to Treat

I consent to the examination, treatment and procedures which may be performed during this visit, including emergency treatment deemed necessary by North Georgia Urgent Care staff. I understand that the examination I am about to receive should not be considered to be in lieu of my ongoing and preventative health care needs, which should be provided by my personal health care provider. I also authorize release of information requested by my insurance company and the release of my medical records (current and historical) to health care providers with whom I or my treating provider(s) may consult medical treatment.

Consent to Procedure if Deemed Necessary

If initialed above, I hereby consent to the performance upon myself of any procedure or treatment deemed necessary, and performed by providers at North Georgia Urgent Care . Any medical procedure may have risk of bleeding, infection, scarring, death and or temporary/chronic pain. Any other specific risks will be explained to me. I agree that the risks have been explained to me to my satisfaction. I further consent to the administration of such local anesthesia as may be necessary and may be considered necessary or desirable in the judgment of the provider; and further, consent to the performance of such additional operations or procedures as are considered necessary or desirable in the judgment of the medical staff. Any tissue or member severed in any operation or procedure will be disposed of at the discretion of the provider.

Patient Name or Representative:_____ Date:_____

Witness_____ Time:_____

Consent for Injection Therapies if Deemed Necessary **Patient Initials:**_____

If initialed above, I have been informed by my provider that all injection treatments are accompanied by possible risk that may include allergic reactions, redness, swelling, numbness, weakness, paralysis or death as a result to injection therapy. I understand that in all injection therapies there is commonly but not always: bruising, temporary increase in pain, inflammation and temporary numbness around the injection site.

I understand that injections may vary depending upon ones diagnosis. Injections may include: nerve blocks, trigger blocks, intramuscular injections, joint injections, and tendon or ligament injections.

I understand that there is no guarantee of successful treatment has been implied. I understand that I am entitled to a copy of this consent form upon request and that I may withdraw this consent upon request in writing at any time.

I have read the above and consent to having any injections as they are needed by orders of the provider. The provider has explained the treatments and/or procedure(s) to me so that I fully understand. I acknowledge that I have been given the opportunity to discuss the nature and purpose of the treatment. I have also been informed of alternate methods of treatment, risk, complications and consequences associated with the administration of medications given by injection. I further acknowledge that all my questions regarding my treatment have been answered to my satisfaction and I have been further told that any additional questions I may have will be answered.

Radiology Consent if Deemed Necessary **Patient Initials:**_____

If initialed above, I acknowledge that the attending provider has deemed necessary that an X-ray will be needed to diagnose or treat my condition. I understand that my provider may need X-rays in order to diagnose my condition and I give permission for the administration of these diagnostic tests.

Females only: *By signing this consent, I acknowledge that X-rays may expose my lower torso to radiation, and if I am pregnant, the exposure may injure the fetus. I have been advised that the ten (10) days following onset of a menstrual period are generally considered to be safe for X-ray exams. With this in mind, I consent that I will advise my provider if I am pregnant, could be pregnant, have an IUD, have had a tubal ligation, had a hysterectomy, irregular menstrual periods, missed my last period or have begun menopause.*

With full understanding of the above, and believing that I am not currently at risk, I wish to have an X-ray examination performed today if it is requested by my provider.

Sign acknowledging that you have reviewed the above information.

Patient Name or Representative:_____ **Date:**_____

Witness:_____ **Time:**_____