Patient Authorization

Medical Treatment Financial Policy

You will be responsible for full payment or payment as indicated by your insurance plan.

If you have insurance....

If My Doctor has a contract with your insurance company we will file today's charges with that insurance company. You will be responsible for your co-payment, co-insurance and/or deductible. And the cost of any services not covered by your insurance. You may receive a bill from My Doctor for any unpaid balance.

If you do not have insurance...

If you do not have insurance coverage or My Doctor does not have a direct contract with your insurance company, you will be required to pay in full for your visit today. You can expect to pay an initial payment for medical care/treatment based on posted pricing in the center. This payment will be collected at check-in.

If the medical provider feels that your treatment requires more complex lab tests, x-rays, supplies or other services, there will be an additional charge for those services in addition to the posted fee for the office visit should you decide to consent to the additional testing/evaluation.

Notice of Privacy Practices

Your name and signature below indicate that you have received a copy of My Doctor's Notice of Privacy Pratices if so requested on the date and time indicated.

Name (please print):____

Signature:________________________________ Date:____________

Release of Medical Records, Assignment of Benefits, Financial Responsibility

I authorize My Doctor Urgent Care to submit claims to my insurance carrier as well as medical records needed to evaluate these claims for payment. I understand that if my employer is responsible for paying all or part of this claim, they will receive the medical information needed to pay this claim and I authorize the release of this information. I further authorize payment of benefits, otherwise payable to me, to be made payable to My Doctor Urgent Care. I understand that I am financially responsible for all charges not covered by insurance.

If my insurance company is not contracted with My Doctor Urgent Care or I have no insurance coverage, I understand that I am financially responsible for all charges and must make full payment today.

Signature of parent or guardian:__________________________________ Date:________________

Consent for Medical Treatment

I give permission to My Doctor Urgent Care to perform the medical and surgical processes, treatment, and/or procedures that the physician and other non-physician providers and assistants may deem necessary. In addition, I authorize My Doctor Urgent Care to release any information obtained during the course of my examination and / or treatment to my health care insurer or other payer.

Signature of Patient /Guardian:__________________________________ Date:________________