

Thank you for choosing Next Level Urgent Care. Our main concern is that you receive high quality care. In order to prevent any misunderstanding and to serve you better, we ask that all patients read and understand our policies. If you have any questions or concerns, please do not hesitate to ask.

CONSENT FOR CARE AND TREATMENT

I, the undersigned do hereby agree and give my consent for NEXT LEVEL URGENT CARE to furnish medical care and treatment to John Johnson considered necessary and proper in diagnosing or treating his/her physical condition.

BENEFIT ASSIGNMENT

I hereby authorize and assign payment to NEXT LEVEL URGENT CARE of any type of reimbursement or payment from Medicare or State Medicaid programs or other third party payor, for any and all costs of my medical care provided at NEXT LEVEL URGENT CARE or by its agents, designees or independent contractors. Further, I understand that some ancillary providers may bill me separately and I assign my insurance benefits to them if their services are rendered during my treatment. I also authorize the release of my medical information needed by my insurance carrier to process any claims.

FINANCIAL POLICY STATEMENT

I have read and understand the Financial Policy of NEXT LEVEL URGENT CARE. I agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies paid, including but not limited to return items fees, collection agency fees, court costs and attorney fees. I understand that NEXT LEVEL URGENT CARE does not collect payment at the time of service, but only collects my method of payment when I am presented with my estimated charges from my visit. I agree that any amount owed after my insurance processes my claim will be satisfied using the payment method on file with NEXT LEVEL URGENT CARE without additional prior notice to me.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

A copy of our financial policy is available on our website at <http://www.nlucc.com/FinancialPolicy.pdf>

PATIENT PRIVACY PRACTICES

I authorize NEXT LEVEL URGENT CARE to release any medical or financial information to a medical care provider who is performing medical care of a diagnostic test on behalf of; or at the request of the health care provider of NEXT LEVEL URGENT CARE. I authorize NEXT LEVEL URGENT CARE, its agencies and designees, to utilize any information in my medical record for quality assurance and risk management activities. **BY STATE LAW**, you must be advised that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease, which includes, but is not limited to diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Symptoms (AIDS). I hereby authorize NEXT LEVEL URGENT CARE to release medical information obtained in the course of my evaluation and treatment to my employer and/or employer's representative (only in the case of job related injury/illness), my primary care physician and my insurance carrier.

A copy of the patient privacy notice is available on our website at <http://www.nlucc.com/PrivacyNotice.pdf>

A copy of our Patient Bill of Rights is available on our website at <http://www.nlucc.com/PatientRights.pdf>

MEDICATION CONSENT

I give permission for NEXT LEVEL URGENT CARE to access my pharmacy benefits data electronically through SureScripts. This consent will enable NEXT LEVEL URGENT CARE to determine the pharmacy benefits and drug co pays for my health plan, check whether a prescribed medication is covered (in formulary) under my plan, display therapeutic alternatives with preference rank (if available) within a drug class for medications, determine if my health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies, and download a historic list of all medications prescribed for me by any provider. We ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using SureScripts.

Patient Name: John Johnson



Signature of Patient/Guardian/Responsible Party: _____

Date: 07/11/2013

There is no expiration date to this document