

CAROLINA QUICK CARE PATIENT AUTHORIZATION, ASSIGNMENT & RELEASE FORM

PATIENT NAME: _____ DATE: _____

I voluntarily consent to health care treatment at Carolina Quick Care, P.A., including diagnostic procedures and medical treatment ordered by the attending physician(s).

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatment or examinations at Carolina Quick Care, P.A. Consequently, I hereby release Carolina Quick Care, PA, Its employees, agents and representatives, and my physicians and their employees and agents, from such legal responsibilities regarding my knowledge of and consent to the medical treatment to the above-named patient ("Patient") and from such other legal responsibilities to the extent permitted by law.

AUTHORIZATION FOR RELEASE OF MEDICAL AND OTHER INFORMATION: The undersigned hereby authorizes Carolina Quick Care,PA to disclose any medical information currently existing or developed during the course of treatment from the patient's medical record to: (1.) the referring physician, including employees/agents thereof, and a health care facility or physician to which the patient may be referred or transferred; and (2.) any representative of: (a) any party financially responsible for the care, including insurance companies, HMO's and self-insured employers (b.) State agencies, (c) any extended care Carolina Quick Care, PA, considered for placement; and (d) third-party billing or coding companies engaged by Carolina Quick Care, pa. This authorization will allow any physician or any other person to have access to the patient's medical records when needed to provide for care and treatment to the patient. I understand that this consent is revocable except to the extent that action has been taken in reliance thereon. I further authorize Carolina Quick Care, PA to release such information as may be requested by any party financially responsible for care and to seek funding on my behalf from Medicaid or other state funds and to make necessary referrals, applications and requests on my behalf.

FINANCIAL RESPONSIBILITY

ASSIGNMENT OF INSURANCE BENEFITS: I authorize direct payment of mental health and medical benefits (not to exceed regular charges for similar services) to Carolina Quick Care, PA. The benefits referred to herein would be payable to me if I did not make this assignment and include Major Medical Insurance. I understand that I am personally responsible to Carolina Quick Care, PA for charges for health care services determined to be non-medically necessary by a private insurers utilization review program.

TRANSFER CREDITS: I hereby authorize the transfer of monies paid to Carolina Quick Care, PA by or on behalf of myself and otherwise refundable to me to other Carolina Quick Care, PA accounts for which I am responsible.

MEDICARE-MEDICAID CERTIFICATION: I certify that the information given by me in applying for payment under Title V.XVIII (Medicare) and/or XIX (Medicaid) of the Social Security Administration is correct. I authorize any holder of medical or other information about me to release the Social Security Administration or its intermediaries or carriers any information needed for this or a related claim. I request that payment for authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization to submit a claim to Medicare for payment to me.

FINANCIAL RESPONSIBILITY: The undersigned, in consideration of health care services rendered or to be rendered by Carolina Quick Care, PA to the patient, guarantees payment to Carolina Quick Care, PA on demand of all charges for services and incidentals provided on behalf of the patient. Additionally, in the event of nonpayment, the undersigned guarantees payment of all costs of collections, including reasonable attorney's fees.

This form has been explained fully to me and I Certify that I understand its contents.

Your signature below indicates approval of the financial responsibilities above.

Signature of Patient: _____ Date: _____ Witness: _____

(IF PATIENT IS UNABLE TO CONSENT, COMPLETE THE FOLLOWING)

Patient is : unable to consent because _____ and I hereby consent on his/her behalf and in his/her stead.

Signature of Legal Guardian: _____ Date: _____ Witness: _____

I acknowledge that I have received a copy of Carolina Quick Cares' Notice of Privacy

Patient/Legal Representative Signature: _____ Relationship to Patient : _____

CAROLINA QUICK CARE CONSENT, ASSIGNMENT, RELEASE FORM

CONSENT FOR MEDICAL TREATMENT: I voluntarily present for treatment and consent to my physician and whomever they may designate as their assistant, associate, treating physician and patient care staff to provide my care. Such care may include, but not be limited to, diagnostic procedures psychotherapeutic treatment, physical therapy, other treatments and medications, pathologic and radiological evaluations and procedures considered advisable in my diagnosis, treatment, and course of care. I acknowledge that no guarantee can be made or has been made as to the results of treatments or examinations at Carolina Quick Care.

RELEASE AND USE OF PATIENT INFORMATION: I authorize the release of my medical records, information, treatment and advice, and specific health information to:

- (1) AN EMPLOYER who requests services (including history, physical, laboratory and diagnostic tests , and screening for the presence of drugs, alcohol or marijuana)
- (2) INSURANCE COMPANY or other third party payer and their agents as well as any review organization or government agency for the purpose of determining eligibility, available benefits and obtaining payment for services provided.
- (3) EDUCATIONAL OR SCIENTIFIC INSTITUTIONS, authorized health care professionals in training, internal quality improvement, risk management, and legal counsel when t is judged that my ongoing medical care, medical research, quality improvement, healthcare education or science will benefit; for any purpose authorized by law.
- (4) TREATING PHYSICIANS on staff at Carolina Quick Care, their agents and allied professionals; to another healthcare facility upon direct transfer and to my attending consulting, referring and/or primary care physicians for follow-up care. I understand that if I refuse to authorize access to my records for coordination if care my treatment could be adversely affected.

I understand this information concerning medical care, advice or treatment may include history and physical/diagnosis/laboratory and diagnostic testing specific information concerning alcohol abuse/mental health/drug abuse/human immune-deficiency virus/hepatitis/or other infectious diseases. I understand that I have the right to revoke this authorization. If my revocation prevents payment or reduces payment for services received, I become responsible for payment.

ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT GUARANTEE: In consideration of services provided by Carolina Quick Care, I hereby assign and transfer to Carolina Quick Care any and all rights, which I have against insurance companies, governmental agencies, or third party payers, for payment of charges for services provided by Carolina Quick Care to me or to one of my dependents. I understand that I am responsible for and will pay the portion of my bill not covered by insurance companies, governmental agencies or third party payers. In consideration of services to be provided, I agree to pay Carolina Quick Care in accordance with the regular rates and terms of Carolina Quick Care. I further agree to pay the account in full upon receipt of my billing statement unless payment arrangements are made with Carolina Quick Care. I authorize said payments to be applied to any unpaid Carolina Quick Care balance for which I am responsible. If my account is placed with a collection agency, an additional 25% will be added to my balance.

I give consent, authorize release, and assign benefits to CQC: _____

Patient/Guarantor Signature

RECEIPT OF HIPPA PRIVACY NOTICE

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how Carolina Quick Care may use and disclose my protected health information . I understand that Carolina Quick Care reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

Printed Patient Name

Date

Signature of Patient or Parent/Guardian

Office Use only (To be used only when patient declines to sign acknowledgement)

Check here if patient declined to sign acknowledgment Staff Initials:

Date:

AUTHORIZATION TO RELEASE MEDICAL INFORMATION (VERBAL AND COPIES) TO MEMBERS OF YOUR FAMILY OR OTHER INDIVIDUALS:

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1966, in order for your physician or the staff of physicians of Carolina Quick Care to give copies of and/or discuss your condition/exams/procedures/or x-rays with members of your family or other individuals that you designate other than your primary care doctor or specialist, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

I authorize Carolina Quick Care to release any and all information (including verbal information, copies of x-rays and medical paper work) concerning my medical care to the following individuals:

Name (Please Print)	Relationship	Phone Number
_____	_____	_____
Name (Please Print)	Relationship	Phone Number

MEDICARE-MEDICAID CERTIFICATION: I certify that the information given by me in applying for payment under Title V.XVIII (Medicare) and/or XIX (Medicaid) of the Social Security Administration is correct. I authorize any holder of medical or other information about me to release the Social Security Administration or its intermediaries or carriers any information needed for this or a related claim. I request that payment for authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization to submit a claim to Medicare for payment to me.

I DO NOT authorize Carolina Quick Care to release any information concerning my medical care to any individual

I authorize Carolina Quick Care to leave a detailed message and/or confirm appointments on my voice mail.
Voice Mail Number: _____

I DO NOT authorize Carolina Quick Care to leave a detailed message or confirm appointments on my voice mail.

I Do authorize Carolina Quick Care to send non medical information via e-mail.

Your Signature

Date

AUTHORIZATION TO DISCUSS FINANCIAL INFORMATION In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1966, we must obtain your authorization to discuss financial information with members of your family or other individuals that you designate other than insurance companies or third party payers and their agents.

I authorize Carolina Quick Care to verbally discuss financial information with:

_____	_____	_____
Name (Please Print)	Relationship	Phone Number
_____	_____	_____
Name (Please Print)	Relationship	Phone Number
_____	_____	_____
Your Signature		Date