URGENT CARE
of Berwick, Midtown, Sandfly, & Wilmington Island

Authorization for Treatment

I authorize the physician and staff of Urgent Care of Your Family Medical Group to treat myself or the person for whom I have responsibility. I understand that this consent to treat includes my consent for medical test, procedures, drugs and other services and supplies as considered advisable; and may include, but is not necessarily limited to: anesthesia, pathology, radiology, and other imaging and diagnostic services, and other special test and services including tests for communicable diseases and toxins, as ordered by the physician responsible for my care during my visit to Your Family Medical Group. I acknowledge that the practice of medicine is not an exact science and no guarantees or promises have been made to me as to the results of examination, care, or treatment at Your Family Medical Group. I acknowledge that it is important for me to provide accurate and complete information regarding my symptoms, medications, drug use, and other information, and that failure to do so can adversely impact my care. I understand I may request a copy of Your Family Medical Group's Notice of Privacy Practices to read and/or take home with me at any time. I understand that if I want more information about these privacy practices or have questions or concerns, I may ask the Center's staff or contact Your Family Medical Group as indicated on the notice.I authorize Your Family Medical Group, or its agents, to release medical or other information to my insurance company, the Center for Medicare and Medicaid Services, or its carriers, as necessary to determine payment for these or related services.

I request that payment authorized by my insurance company, the Center for Medicare and Medicaid Services, or its carriers, be made on my behalf to Your Family Medical Group for services provided by said group. I certify that any information I provide related to my eligibility for coverage or payment is accurate and complete. I understand that I am required to notify Your Family Medical Group of any change in insurance Coverage. I understand I am financially responsible for payments of services provided during the visit if I do not have insurance coverage or if I have coverage and timely payment is not made. I also understand that if I have a co-payment for this service, it is payable today. I understand that I am responsible for paying the amount of any discount imposed if my insurance provider or third- party payer imposes a discount, which are not authorized by a signed agreement between that payer and Your Family Medical Group **Certain lab tests may be sent to an independent lab for processing. I understand I may receive a separate bill for these services. Your Family Medical Group utilizes LabCorp for all Send Out labs. Radiology services may result in an additional bill from the Radiologist from Coastal Imaging and any specialty orthopedic products will be billed by DJO, LLC.** Some insurance companies require preauthorization for certain services. If I am required to obtain an authorization for today's visit and have not done so, I agree to assume all financial responsibility. If I receive any additional services from specialists, hospitals, or other healthcare providers in connection with or because of this visit, those charges may also be my responsibility, unless preauthorized as required by my insurance company. I understand and agree that invoices for patient balances due may be emailed directly to the email address provided on registration. If collection procedures are initiated on any outstanding balance, I agree to be responsible for the costs of collection including, but not limited to court costs, expenses, and attorney fees, to the extent permitted by law. I understand that the foregoing provisions apply equally to any individual for whom I am authorized to consent to treatment, or for whom I qualify as an authorized representative or authorized agent under any laws.

_____ **Patient's Date of Birth: _____**

Patient's Name (please print clearly)

_____ **Today's Date: _____**

Patient's or Parent/Legal Guardian Signature

Street Address: _____ Building/Apartment #: _____

City: _____ State: _____ Zip: _____

Cell Phone #: _____ Email:_____@_____.com

Reason for Today's Visit: _____

Is this a worker's comp visit? (Y/N) _____Is this a visit for a car accident? (Y/N) _____

Have you changed insurance carriers? (Y/N) _____ *If you answered "NO", please skip the rest of this form and present ID and Insurance to Medical Receptionist.*

If "YES", what is the name of the new insurance? _____

Subscriber's Full Name: _____ Date of Birth: _____/____/_____

Subscriber's Sex: ____ Relationship to Patient: _____

Please present the receptionist with new insurance and ID.

Berwick: 5730 Ogeechee Road, Suite 192 | Savannah, Georgia 31405 | 912.201.1140 (t) | 912.777.6449 (f)
Sandfly: 7360 Skidaway Road, Suite L2 | Savannah, Georgia 31406 | 912.201.1140 (t) | 912.999.6271 (f)
Wilmington Island: 212 Johnny Mercer Blvd. | Savannah, Georgia 31410 | 912.201.1140 (t) | 912.344.4857 (f)
Primary Care: 310 Eisenhower Dr, Suite 12A| Savannah, Georgia 31406| 912.201.1140 (t)| 912.417.4348 (f)