URGENT CARE
of Berwick, Sandfly & Wilmington Island

Authorization to Treat

I authorize the physician and staff of Your Family Medical 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: radiology and other diagnostic services, as well as other special test and services as ordered by the physician responsible for my care during my visit to Your Family Medical. 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. 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's Notice of Privacy Practices to read and/or take home with me at anytime. 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 as indicated on the notice.

I authorize Your Family Medical, 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 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 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. I also understand that if I have a co-payment for this service, it is payable today. **Certain lab tests may be sent to an independent lab for processing. I understand I may receive a separate bill for these services. 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 todays visit and have not done so, I agree to assume all financial responsibility.

In the event that 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.

Skidaway Medical Group is responsible for the management of, and has a financial interest in Primary Care Savannah and Urgent Care of Berwick/Urgent Care of Sandfly. Our goal is to enhance access to quality health care services for our patients. Referrals to alternative providers and/or facilities will be made available to the patient upon request. Ongoing patient care is in no way contingent upon the patient accepting the recommended referral.

_____ **Date:** _____

Patient's Signature (If patient is a minor, have guardian or representative sign in their place)

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

Print Patient's Name Clearly

Address _____**City/Zip** _____

Home Phone #_____**Cell Phone #**_____**Work Phone #**_____

Reason For Today's Visit _____

YOUR FAMILY
MEDICAL GROUP

PATIENT INFORMATION

Today's Date: _____ Gender: _____ Date of Birth: _____/_____/_____ Age: _____

Last Name: _____ First Name: _____MI: _____

SSN# _____--_____--_____ E--mail Address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home #: (_____) _____--_____ Work #: (_____) _____--_____ Cell # : (_____) _____--_____

Employer:_____

Race/Ethnicity _____ Preferred Language: _____

Marital Status: (Circle) Single Married Divorce Separated Partnered Widowed

Emergency Contact: _____ ***Relationship to Patient:*** _____

Emergency Contact Phone #: _____

INSURANCE INFORMATION

Primary Insurance: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____/_____/_____

Subscriber's SSN : _____--_____--_____

ID #: _____

Group #: _____

Secondary Insurance: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____/_____/_____

Subscriber's SSN: _____--_____--_____

ID #: _____

Group #: _____

Reason for today's visit: _____

If Injured: Where you injured on the job? (Circle) Yes No Injury Date: _____

Signature of Responsible Party:_____ Date: _____/_____/_____

Please continue to the next page for your office visit details and sign the authorization to treat.

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)
Primary Care: 310 Eisenhower Dr, Suite 12A • Savannah, Georgia 31406 • 912.201.1140 (t) • 912.417.4348 (f)