Patient Consent and Authorization

Healthcall Medical Center, LLC

Plainfield Walk-In and Medical Center

558 Norwich Rd, Plainfield CT 06374

Consent to Treatment:

I understand that medical treatment of an immediate nature is necessary for the patient and that such medical care, treatment, and procedures will be performed by the independent physicians and by employees of Plainfield Walk In and Medical Center during the hours of operation only. I understand that immediate medical treatment only is being provided and that no responsibility will be taken for long-term patient care or care outside our hours of operation. I hereby grant my authorization and consent to such treatment and procedures, and certify that no guarantee or assurance has been made as to the results, which may be obtained.

Personal Physician:

I am aware that if the provider is not the patients primary care provider or the provider does not participate with the patient’s health insurance plan, I will be responsible for any applicable charges.

Third Party Payers:

I hereby give permission to the patient’s third-party payer (employer, insurance carrier, workers compensation insurance, etc.) to directly pay Plainfield Walk-In and Medical Center, LLC for services rendered to the patient. It is the patient’s ultimate responsibility to understand what their insurance will cover.

Agreement to Pay for Services:

For and in consideration of the care and treatment provided to the patient, I promise to pay Plainfield Walk-In and Medical Center, LLC all charges for services rendered to or on behalf of the patient. This may include any claims denied by the patient’s third-party insurance carrier, including any claims denied by workers compensation insurance carrier. I promise to pay any and all collection costs, including attorney fees, allowable by law. Co-payments and deductibles are due at the time of service. A service charge of $10 will be charged if co-payments are not payed within 30 days. There is a $20 service charge for all returned checks.

Release of Medical Information:

I hereby authorize the Plainfield Walk-In and Medical Center, LLC to release private health care information in connection with these services for treatment, payment, and healthcare operations. I also authorize the release of medical information pertaining to any occupational healthcare, provided to the patient at this facility, to the patient’s employer, insurance company, and medical provider involved in the diagnosis.

This authorization will remain in effect until revoked by the patient in writing except to the extent that the practice has already made disclosures in reliance upon the patient’s prior consent.

My signature below indicates that I have read and understand each of the statements above.

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship (if not the patient):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_