PATIENT AUTHORIZATION

CONSENT FOR TREATMENT: Urgent Care of Stuttgart and their employees evaluate and treat the patient listed below for a medical complaint or illness. This includes taking of medical information, evaluation by physical examination, obtaining of bodily fluids for laboratory testing, obtaining of X-rays for diagnosis, the administration of medications for treatment, and any other treatment that may be necessary. If, at any time, I do not wish to have these services rendered, I may state so and they will not be provided, but an AMA form may need to be signed by the patient. All my information will remain confidential. ****You expressly consent and agree that, in order to discuss or service your accounts(s) (the "Accounts") or to collect amounts you may owe, Urgent Care of Stuttgart, and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively, "We") may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contact you by sending text messages, emails, using any e-mail address you provide to us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: I acknowledge that I have been offered a copy of the Notice of Privacy Practices for Urgent Care of Stuttgart. A copy is available to me upon request.

ASSIGNMENT OF BENEFITS: I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to URGENT CARE OF STUTGART for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I authorize the release of any medical information for services necessary to process any claim(s). I agree to be responsible for any deductible, co-insurance, copay or any other balance not paid by my insurance.

FINANCIAL POLICY: The following information is provided to avoid any misunderstanding or disagreement concerning payment of professional services. PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE. Co-payment will be collected before you are seen. If you have insurance that we do not participate in or have no insurance (self-pay), payment in full is expected at the time of service. If you have questions about your insurance coverage, we will be happy to assist you. Specific coverage issues should be directed to your insurance company. It is however, understood and agreed that the patient/guarantor is responsible for all monies due for services rendered in the event insurance does not pay. ***If lab test must be sent out to an outside source for further evaluation, the responsible party understands they will be responsible for the charges from that facility. **ALL CHARGES ARE AN ESTIMATE AND FINALIZED WHEN YOUR INSURANCE COMPANY PROCESSES YOUR CLAIM. A $30 NSF FEE WILL BE APPLIED TO YOUR ACCOUNT IF YOUR CHECK IS RETURNED FROM THE BANK.**

By signing below, I agree that I have read and understand the terms of this authorization.

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PATIENT OR GUARANTOR SIGNATURE PRINT PATIENT OR GUARANTOR NAME DATE

*******TURN PAGE OVER********