Please ***initial and sign*** to **select** your current **method of coverage**, and to complete the acknowledgement and consent for Medical Treatment, Notice of Privacy Practices, and Payment Policy.

___Self-Pay (FFS) Patient Visit

By signing below, I acknowledge that I have been informed of my responsibility to pay for the professional services or supplies provided to me today by DRX WA Urgent Care Providers PLLC, dba "Immediate Clinic".
I understand that these costs must be paid prior to the provision of such services through its authorized representatives.
I acknowledge and fully understand that the service(s) requested today will not be billed to any insurance carrier(s) at my request. I also understand that today's service(s) will be provided at a discounted rate and waive any right that I may have to require Immediate Clinic to attempt to bill any insurance carrier for these services. I further acknowledge that if I choose to submit an itemized receipt to any insurance carrier(s) for evaluation of partial or full reimbursement for these services that Immediate Clinic is exempt from any subsequent dispute regarding reimbursement but retains the option to submit these services for payment under the non-discounted insurance rates and guidelines upon mutual agreement by both parties when appropriate insurance information has been provided to Immediate Clinic.

___Health Insured Patient Visit

I request that payment of authorized insurance benefits, including Medicare, be made on my behalf for any professional services or supplies provided to me by DRX WA Urgent Care Providers PLLC, dba "Immediate Clinic".
I acknowledge that I have provided my insurance information today and authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related professional services or supplies by Immediate Clinic to the Health Care Financing Administration, my insurance company or other entity upon request to secure payment of my benefits.
I understand that I am financially responsible to Immediate Clinic for any charges not covered by health care benefits. It is my responsibility to notify Immediate Clinic of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I understand that I am responsible for the entire bill including any unpaid balance of the professional services or supplies as determined by Immediate Clinic and/or my health care insurer should the submitted claim or any part of the claim be denied for payment or apply to my co-pay, deductible or coverage limitations.

___CONSENT TO MEDICAL TREATMENT

I voluntarily present for treatment and consent to my Immediate Clinic provider to provide my care. Such care may include, but is not limited to, diagnostic procedures, x-rays, blood draws, laboratory tests, medication administration, and other procedures considered advisable in my diagnosis, treatment and course of care.
I acknowledge that my treatment is intended to address specific, episodic illnesses or injuries and is not intended as a substitute for a primary care physician or other specialized physician and that no guarantee can be made or has been made as to the results of treatments or examinations at Immediate Clinic.

___NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge review of Immediate Clinic's Notice of Privacy Practices, with a copy available upon request, as required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

___OFFICE POLICY ON PAYMENT

It is our policy to require all co-payments to be made at the time of service. All accounts over 60 days, after processed by the provided insurance, will be charged an interest rate of 2% a month or a $2.00 minimum. In the event any balance is not paid as agreed, the undersigned agrees to pay all costs charged by the Collection Company and reasonable attorney fee.
I understand that by signing this form I am accepting full financial responsibility as explained above for all professional services and supplies received. I understand this original authorization will be kept on file by Immediate Clinic and does not expire unless written notice is provided by me.

Name of person signing below (print):

_____

Signature of Patient or Guardian:

_____

Today's (Visit) Date:

_____

Relationship to Insured:
☐Self ☐Spouse ☐Dependent ☐Other

Relationship to Patient:
☐Self ☐Spouse ☐Guardian ☐Other