



**The
DOCTORS Center
Urgent Care.**

A Service of Southwest Medical Strategies

Northwest • SPID • South

Consent for Treatment/Privacy Policy/Assignment of Benefits

Patient Name: _____

DOB: _____ SSN: _____

The undersigned, being the patient and/or guaranteeing party to the above name account hereby acknowledges and agrees to the following:

- I. **CONSENT FOR TREATMENT:** I hereby consent to the evaluation and management services provided by The Doctors' Center. Services may include diagnostic radiology. I understand that my consent may be revoked, in writing, at any time. However, such revocation does not release any financial obligation for services already rendered.
- II. **AUTHORIZATION TO RELEASE/OBTAIN INFORMATION:** The undersigned hereby authorizes The Doctors' Center to release to any insurance carrier represented as contractually responsible for payment in whole or in part of the patient's health care bill, such information as is deemed minimally necessary for the proper and accurate processing of such healthcare claims. Further, the undersigned releases The Doctors' Center to provide to outside healthcare providers/services such information as is necessary to facilitate proper healthcare, limited only to that which is deemed minimally necessary to execute referrals, etc. on behalf of the patient. In addition, by copy of this document the patient consents to the release of prior medical records from referring physicians, hospitals, nurses, or other entities, which have records necessary for proper evaluation and treatment of the patient.
- III. **PRIVACY STATEMENT:** The undersigned hereby acknowledges the privacy policy of The Doctors' Center will administer our patient records in a confidential manner and in compliance with Health Insurance Portability and Privacy Act. Any and all patient information will only be released with proper authorization. Patient information shall not be sold to any outside marketing firms, and will not be included in any medical studies without explicit and separate authorization of the patient.
- IV. **AUTHORIZATION TO RELEASE INFORMATION TO EMPLOYER:** The undersigned hereby authorizes The Doctors' Center to release information to my employer regarding my work status, physical capability with regard to my job, treatment plan information as it relates to my ability to perform my job, and information with regard to possible job loss time and expected duration of disability. Only information deemed minimally necessary for these purposes shall be transmitted to the employer. I understand that The Doctors' Center must abide by statutes of the Texas Workers' Compensation Commission and shall transmit the required format in accordance with such statutes.

I also understand that work status is determined by the physician and is based on physical capability alone. I understand that the physician may restrict my work duty within the limits of my physical capability. My employer may or may not have work status to accommodate availability of work with my employer.

- V. **STATEMENT OF FINANCIAL RESPONSIBILITY:** In consideration of medical treatment and service provided to the above-named patient, the patient or the undersigned guarantor unconditionally guarantees payment in full to The Doctors' Center. The Doctors' Center agrees to abide by the terms and conditions set forth in individual managed care contracts with which the patient and physician both participate. Patient covered by insurance that do not have a managed care contract with The Doctors' Center understand that The Doctors' Center will submit claims for processing. However, the patient/guarantor is ultimately responsible for payment of the entire account balance regardless of insurance coverage or insurance benefit determination. Should an insurance carrier not pay on a claim within a mandatory 45-day state limit, the balance will be the responsibility of the patient/guarantor. All copays are due at the time of service. The patient/guarantor understands he/she is responsible for providing accurate and complete billing information.
- VI. **ASSIGNMENT OF INSURANCE BENEFITS:** The undersigned hereby authorizes any insurance carrier represents as contractually responsible for payment in whole or in part of the patient's healthcare bill, to pay directly to The Doctors' Center.

I acknowledge and accept the terms and conditions set forth in Sections I through VI of this policy statement:

Signed: _____ Date: _____

Effective Date 4/23/04

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