South Baldwin Medical Center – Gulf Shores

f/k/a Alabama Gulf Coast Urgent Care Center

CONSENT FOR MEDICAL TREATMENT

1) GENERAL CONSENT FOR TEST, TREATMENT AND SERVICES

I hereby voluntarily consent for treatment. I permit the facility and its employees, physicians and others involved in my care to treatment in ways they judge to be beneficial tome. I understand that I have the right to ask questions and to receive information about my care and treatment, and the right to withdraw my consent for treatment or tests. I consent to examinations, blood tests (including blood tests for communicable diseases such as hepatitis and HIV/AIDS when healthcare personnel have been exposed to my blood and/or body fluids), laboratory and imaging procedures, medications, infusions, nursing care and other services or treatments rendered by my physician, consulting physicians and their associates and assistants, or rendered by Facility personnel under the instructions, orders or direction of such physician(s).

I agree and understand that no physicians, consulting physicians and their associates and Facility are responsible or liable for the acts or omissions of the aforementioned. Independent contractors who are not employed by the Facility may perform some services. I am aware that the practice of medicine is not an exact science and further understand that no guarantee has been or can be made as to the results of the treatments, care or examinations in the Facility.

2) NURSING CARE

The facility provides only routine care.

3) PERSONAL VALUABLES

I understand that the Facility does not maintain a safe for safekeeping of money and valuables, and the Facility shall not be liable for the loss or damage of any articles of personal property.

4) ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY

I hereby assign and authorize payment directly to the facility, and to any facility-based physician, all insurance benefits, sick benefits, injury benefits due because of liability of a third-party or proceeds of all claims resulting from the liability of a third party, payable by any party, organization, et cetera, to or for the patient unless the account for this facility, outpatient visit or series of patient visits is paid in full completion of the services. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand that I am responsible for any charges not covered by my insurance company.

I understand that I am obligated to pay the account of the Facility in accordance with the regular rates and terms of the Facility. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Facility visit may be applied directly to any delinquent account for which my guarantor or I is legally responsible at the time of the collection of the overpayment.

5) WEAPON / EXPLOSIVES / DRUGS

I understand and agree that if the Facility at any time believes there may be a weapon, explosive device, biohazard material, any type of illegal substance of drug, or any alcoholic beverage on my person or personal belongings, the Facility may conduct a search and confiscate any of the above items that are found, and dispose of them as it determines appropriate including delivery of any item to law enforcement authorities.

6) NOTICE OF PRIVACY PRACTICES [*Required pursuant to Health Insurance Portability and Accountability Action of 1996 (HIPAA)]*

I acknowledge that I have received a copy of the Facility's Notice of Privacy Practices that provides information about how the Facility may use and disclose my protected health information.

The undersigned certifies that he/she has read the foregoing, understands it, accepts its terms, has received a copy of it and is the patient or is duly authorized by the patient as their agent to execute the above.		
Patient's Signature or Legal Representative	Date	
Relationship to Patient	Interpreter, if utilized	
Witness Signature	If Telephone Consent, Second Witness Signature	
Conditions of Treatment and Consent to Medical Treatment **ADM-1701GSR – (10/06)**	**ADDRESSOGRAPH / PATIENT LABEL**	

PATIENT INFORMATION

NAME: (LAST) _____ **(FIRST)** _____ **(MIDDLE)**_____**SR./ JR / II/ III**

MALE: _____ FEMALE: _____ PATIENT'S DATE OF BIRTH_____

SOCIAL SECURITY #_____ **CIRCLE ONE: SINGLE MARRIED SEPARATED DIVORCED WIDOW/WIDOWER**

MAILING ADDRESS:_____ **CITY**_____ **STATE**_____ **ZIP**_____

PHONE HOME: _____ CELL _____ LOCAL_____

PRIMARY CARE PHYSICIAN:_____ **PHONE #**_____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____

PHONE:_____ **CELL :**_____

WAS THIS AN ACCIDENT? Y / N AUTO: _____ WORKER'S COMP: _____ OTHER: _____

BILLING INFORMATION

PERSON RESPONSIBLE FOR PAYMENT—WE BILL AS AN OFFICE VISIT NOT URGENT CARE

CIRCLE ONE: PATIENT PARENT SPOUSE OTHER

NAME: _____ DATE OF BIRTH: _____SOCIAL SECURITY # _____

MAILING ADDRESS IF DIFFERENT FROM ABOVE: _____

PHONE: _____ CELL: _____ WORK: _____

OCCUPATION: _____ EMPLOYER'S NAME & ADDRESS: _____

_____

INSURANCE INFORMATION

1. PRIMARY INSURANCE: _____
INSURANCE COMPANY NAME

_____ _____ _____
POLICY HOLDER'S NAME **DATE OF BIRTH** **SOCIAL SECURITY #**

_____ _____ _____
POLICY ID NUMBER **GROUP NUMBER** **PATIENT'S RELATIONSHIP TO POLICY HOLDER**

2. SECONDARY INSURANCE: _____
INSURANCE COMPANY NAME

_____ _____ _____
POLICY HOLDER'S NAME **DATE OF BIRTH** **SOCIAL SECURITY #**

_____ _____ _____
POLICY ID NUMBER **GROUP NUMBER** **PATIENT'S RELATIONSHIP TO POLICY HOLDER**

3. TERITARY INSURANCE: _____

FINANCIAL POLICY

We strongly feel all patients deserve the very best medical care that we can provide. Everyone benefits when financial arrangements are agreed upon. We have prepared this material to acquaint you with our policy.
Our professional services are rendered to you, not the insurance company. Payment for treatment is your responsibility.

FINANCIAL AGREEMENTS
PLEASE INITIAL IF APPLIES TO PATIENT

_____ *I* ***HAVE NO INSURANCE COVERAGE*** I understand that I am responsible for payment of services rendered to myself or dependents at the time of service.

INSURANCE AUTHORIZATION AND ASSIGNMENT
**** PLEASE INITIAL ALL THREE****

_____ I hereby authorize the ***RELEASE OF ANY INFORMATION NECESSARY*** to process insurance claims and request payment of benefits to be made for services rendered to my dependents or myself.

_____ I understand I am responsible ***AT THE TIME OF SERVICE*** for paying any required co-payment and/or deductible.

_____ Check with your insurance company to verify your eligibility; ***WE BILL AS AN OFFICE VISIT.***
South Baldwin Medical Center –Gulf Shores process all claims as an "Office Visit" and not as an "Urgent Care / Emergent Visit". Some insurance may require a referral from your primary care physician.

MEDICARE/MEDIGAP
PLEASE INITIAL IF APPLIES TO PATIENT

FOR MEDICARE PATIENTS ONLY _____
MEDICARE NUMBER

_____ I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Finance Administration or it's intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

MEDIGAP (Authorization Statement) _____
POLICY NUMBER

_____I authorize any holder of medical or other information about me to be released to process this Medigap claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or to the party who accepts assignment.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY OF THIS OFFICE AND AGREE TO ABIDE BY THE SAID POLICY.
****OTHER'S ALLOWED ACCESS TO MY MEDICAL RECORDS: _____**

SIGNATURE:_____
PATIENT/PARENT/GUARDIAN:_____Date_____
I will be paying by: _____Check _____Cash _____MasterCard/Visa/Discover/American Express
There will be a $30.00 charge on all returned checks.

Patient Call Back Survey: Yes or No / Call: Home, Cell or Other: _____
Are you a member of SENIOR CIRCLE? ____YES ____NO HEALTHY WOMEN? ____YES ____NO
How did you hear about our Clinic? _____ER ___Healthy Woman ___Senior Circle ___Physician Advertising ___Hospital Advertising ___Internet ____Physician Referral ___Insurance Referral ____Family or Friend ___Other, please share source_____