PATIENT CONSENT TO TREAT AND ACKNOWLEDGEMENT OF PRIVACY PRACTICES

CONSENT FOR EVALUATION AND TREATMENT

I consent to medical treatment from U.S. HealthWorks Medical Group (USHW), its affiliates, physicians, and employees. Treatment may include any necessary examination, test, or medical procedures ordered by the physician(s) to be performed by USHW staff. I understand I may refuse treatment at any time. If I am seeking non-regulated substance abuse testing, I authorize USHW to obtain a specimen of my urine, blood, saliva, breath, hair, or other specimen to determine the presence of drugs or alcohol. I understand that some physical exams (like fitness for duty, school, or sports) and other services are not intended to diagnose medical conditions or replace the medical care of my personal physician.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have reviewed or have been given an opportunity to review the USHW Notice of Privacy Practices (NPP). I have had an opportunity to ask questions about it and received satisfactory answers. I may ask for a copy of the NPP or can view it electronically at http://www.ushealthworks.com

ASSIGNMENT OF BENEFITS / FINANCIAL RESPONSIBILITY AGREEMENT

- If I am being treated as an urgent care patient for a non-work-related injury and I have health insurance, I assign to USHW all payments under the terms of my applicable insurance policies.

- If I am being treated as an urgent care patient for a non-work-related injury and I **do not** have health insurance, I understand I am responsible for payment. I have a right to ask for the charge amounts before electing treatment.

- If I am treated for a workers' compensation injury or illness, USHW will seek payment from the responsible payer, which is typically the employer or the employer's workers' compensation insurance carrier. I may be responsible for a co-payment where allowed by law.

- If I am receiving employer-directed services (e.g. drug testing, physicals, medical surveillance) USHW will seek payment from the employer. I may be responsible for payment if allowed by State or Federal law.

- If I am responsible for payment and my account is referred to collections, I understand that I may have to pay collection expenses incurred by USHW.

SIGNATURE

Patient Signature:_____ Date:_____

Patient Name:_____ Date of Birth:_____

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