



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

**CONSENT TO TREATMENT**

I CONSENT TO THE PERFORMANCE OF MEDICAL SERVICES, ADMINISTRATION OF MEDICATION AND OTHER MEDICAL PROCEDURES (“SERVICES”) BY (“PROVIDER”) AT CHESAPEAKE ERGENT CARE, AS DEEMED APPROPRIATE BY PROVIDERS MEDICAL PERSONNEL. I UNDERSTAND THAT MEDICAL CARE IS NOT AN EXACT SCIENCE AND NO GUARANTEES HAVE BEEN MADE REGARDING THE OUTCOME OF TREATMENT. I CERTIFY THAT I HAVE READ THE FOREGOING, AND AM THE PATIENT, THE PATIENT’S LEGAL REPRESENTATIVE OR AM DULY AUTHORIZED BY THE PATIENT AS THE PATIENT’S AGENT TO EXECUTE THIS CONSENT OF TREATMENT, AS WELL AS ADDITIONAL CONDITIONS OF SERVICE, AND TO ACCEPT ITS TERMS.

**X-RAY TREATMENT**

WE MIGHT TAKE X-RAYS DURING YOUR VISIT. WHILE WE READ AND PROVIDE AN INITIAL INTERPRETATION OF IMAGING TO THE BEST OF OUR ABILITY, WE CANNOT GUARANTEE OUR FINDINGS WILL BE COMPLETE. IN ALL CASES WE RECOMMEND PATIENTS FOLLOW UP WITH A PRIMARY CARE PROVIDER, RADIOLOGIST OR OTHER SPECIALIST IF THERE IS NO IMPROVEMENT OR A WORSENING OF SYMPTOMS IN THE 24-72 HOURS AFTER THE VISIT. WE WILL PROVIDE YOU WITH A DIGITAL COPY OF THE X-RAY IMAGING TO TAKE WITH YOU. YOUR SIGNATURE BELOW INDICATES YOUR UNDERSTANDING OF THIS AND YOUR CONSENT TO THE PROCEDURE.

**AUTHORIZATION AND RELEASE**

I AUTHORIZE DRS ERGENT CARE D/B/A CHESAPEAKE ERGENT CARE TO RELEASE ANY INFORMATION INCLUDING DIAGNOSIS AND THE MEDICAL RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH CARE TO THIRD PARTY PAYERS AND/OR HEALTH PRACTITIONERS. I ALSO AUTHORIZE AND REQUEST MY INSURANCE TO PAY DIRECTLY TO DRS ERGENT CARE D/B/A CHESAPEAKE ERGENT CARE INSURANCE OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY INSURANCE MAY NOT PAY FOR ALL BILLED SERVICES, THEREFORE I TAKE RESPONSIBILITY TO PAY ALL REMAINING BALANCES FOR SERVICES RENDERED. IT IS MY ACKNOWLEDGMENT TO PAY ANY AND ALL COLLECTIONS FEES ASSOCIATED WITH CARE PROVIDED.

**NOTICE OF PRIVACY PRACTICES**

I ACKNOWLEDGE THAT I HAVE BEEN PROVIDED THE OPPORTUNITY TO REVIEW AND OBTAIN A COPY OF THE CHESAPEAKE ERGENT CARE NOTICE OF PRIVACY PRACTICES, WHICH ALSO IS POSTED ON ITS WEBSITE.

**RELEASE OF INFORMATION**

I HAVE REVIEWED, AGREE WITH, AND HEREBY AUTHORIZE PROVIDER AND ANY OTHER HOLDER OF INFORMATION ABOUT ME TO DISCLOSE ALL OR ANY PART OF MY MEDICAL RECORD OR OTHER INFORMATION NEEDED TO DETERMINE MY ELIGIBILITY FOR BENEFITS OR THE AMOUNT OF BENEFITS PAYABLE FOR SERVICES RENDERED BY CHESAPEAKE ERGENT CARE (“PROVIDER”), NOW OR IN THE FUTURE, TO ANY FINANCIALLY RESPONSIBLE PARTY, INCLUDING BUT NOT LIMITED TO: THE CENTERS FOR MEDICARE AND MEDICAID (CMS), MEDICAID, THEIR INTERMEDIARIES OR CARRIERS, WORKER’S COMPENSATION CARRIERS, HEALTH OR LIABILITY INSURERS, OR ANY OTHER INSURANCE ORGANIZATION OR BILLING AGENT (COLLECTIVELY, “INSURER”). I AUTHORIZE ANY HOLDER OF MEDICAL AND BILLING INFORMATION ABOUT ME TO RELEASE PROVIDER OR ANY INSURER ANY INFORMATION NECESSARY FOR BILLING AND PAYMENT PURPOSES. I CONSENT TO THE USE OF A COPY OF THIS AUTHORIZATION IN LIEU OF THE ORIGINAL.

**ASSIGNMENTS OF BENEFITS**

I REQUEST AND AUTHORIZE DIRECT PAYMENT TO PROVIDER OF ANY MEDICARE AND OTHER INSURANCE BENEFITS PAYABLE TO ME OR ON MY BEHALF FOR SERVICES RENDERED BY CHESAPEAKE ERGENT CARE (PROVIDER), NOW OR IN THE FUTURE. AT PROVIDER’S ELECTION, I ALSO ASSIGN TO PROVIDER ALL MY RIGHTS AND INTERESTS IN ALL SUCH ISURANCE BENEFITS OR PROCEEDS, INCLUDING BUT NOT LIMITED TO THE RIGHT TO APPEAL ANY DENIAL OF BENEFITS OR TO FILE ANY LAWFULLY AUTHORIZED LIEN NECESSARY TO SECURE PAYMENT FROM ANY THIRD PARTY OR A THIRD PARTY’S INSURER. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE SERVICES RENDERED BY PROVIDER AND AGREE TO IMMEDIATELY REMIT ALL PAYMENTS RECEIVED FROM INSURANCE FOR THOSE SERVICES. I AGREE TO COOPERATE WITH PROVIDER OR ITS AGENTS IN COLLECTING ANY SUCH BENEFITS. THIS ASSIGNMENT SHALL NOT OBLIGATE PROVIDER TO FILE ANY APPEAL OR PERFECT ANY SUCH LIEN AND NOTHING HEREIN SHALL RELIEVE ME FROM DIRECT FINANCIAL RESPONSIBILITY FOR ANY CHARGES NOT PAID BY AN INSURER. I ACKNOWLEDGE THAT I HAVE REVIEWED AND AGREE WITH THE ASSIGNMENT OF BENEFITS.

**FINANCIAL RESPONSIBILITY**

PAYMENT IN FULL IS DUE AT TIME OF SERVICE. I ACKNOWLEDGE THAT MANY INSURERS WILL ONLY PAY FOR SERVICES THAT THEY DETERMINE TO BE MEDICALLY NECESSARY AND THAT MEET OTHER COVERAGE REQUIREMENTS. FOR EXAMPLE, SOME INSURERS REQUIRE PRIOR AUTHORIZATION FOR CERTAIN SERVICES. IF MY INSURER DETERMINES THAT THE SERVICES, OR ANY PART OF THEM, ARE NOT MEDICALLY NECESSARY OR FAIL TO MEET OTHER COVERAGE REQUIREMENTS, THE INSURER MAY DENY PAYMENT FOR THAT SERVICE. NOTWITHSTANDING ANY OTHER PROVISION HEREIN, I AGREE THAT IF MY INSURER DENIES ALL OR ANY PART OF CHESAPEAKE ERGENT CARE (“PROVIDER’S”) CHARGES FOR ANY REASON, OR IF I HAVE NO INSURANCE, I WILL BE PERSONALLY AND FULLY RESPONSIBLE FOR PAYMENT OF PROVIDER’S CHARGES. SHOULD MY ACCOUNT BE REFERRED TO AN ATTORNEY OR COLLECTION AGENCY, I AGREE TO PAY ACTUAL ATTORNEY’S FEES AND COLLECTION EXPENSES. ALL DELINQUENT ACCOUNTS SHALL BEAR INTEREST AT TWELVE PERCENT PER ANNUM, NOT TO EXCEED THE MAXIMUM AMOUNT PERMITTED BY LAW. I ACKNOWLEDGE THAT I HAVE REVIEWED AND AGREE WITH THE FINANCIAL REPONSIBILITY.

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**SIGNATURE**

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**DATE**



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Dear Patient,

Thank you for choosing Chesapeake ERgent Care for your healthcare needs. We value our relationship with you and would like to tell you about the financial aspects of our services. Some of the information outlined within this policy include our obligations to comply with insurance, Federal, Privacy and Fair Collections Acts. Your financial responsibilities related to your healthcare are included as well.

### **Red Flags Rule**

The federal Trade Commission developed a set of rules to protect consumers against identity theft. To protect your identity, we require a photo ID and Insurance cards at each visit.

### **HIPPA**

In compliance with HIPPA regulations, we are unable to discuss details of services rendered or to produce an itemized bill for any parties that are not the patient, unless authorized in writing by the patient.

### **Medical Fees and Payments**

Fees are based on the complexity of your visit or procedure. Unmet deductibles, co-payments and outstanding balances are due at the time services are rendered. We accept Visa, Master Card, American Express, Discover, cash, and money order. We accept secured payments over the phone at 410-721-2333.

### **Form Completion and Medical Records**

We charge \$10.00 for the completion of forms including but not limited to disability documents. We also adhere to Maryland State Medical Records copying fees outlined in our Medical Records Copying Protocol.

### **Returned Check Charge**

Non-Sufficient Funds (NSF) are subject to a \$25 fee (in addition to fees from your bank). Cash payments will be expected after more than one NSF fee.

### **Self-Pay Patients**

Our practice will give you an estimate of what will be due. Sometimes it is medically necessary to add services. When this occurs, our Providers will notify you. Payment for services are due at your visit. There might be instances in which you are billed for the services added to your visit.

### **Payment Plans**

In some instances, our office will work with you to develop a plan to assist you in paying outstanding balances with our practice. Contact our billing department at 410-721-2333.

**Minor Patients**

Parent(s) or guardian(s) accompanying a minor for medical services are responsible for providing insurance information and payment of the services rendered to the minor child.

**Global Care**

To assist our patients with understanding insurance benefits we will verify your coverage. Sometimes your insurance will leave you with an out of pocket expense. We allow a monthly payment plan to help you take care of this balance. Full payment is expected prior to service completion.

**Coordination of Benefits**

You may have more than one insurance company assisting you with your medical expenses. Your secondary or tertiary insurance will require that you inform us the correct billing sequence.

**Non-Payment of Outstanding Accounts**

We make many efforts to assist our patients with managing their medical bills. Please contact us if you are having difficulty with payments. Accounts that are not paid in a reasonable amount of time will be sent to an external collection agency. Should the account referred to a collection agency or an attorney for past due amounts, the patient shall incur attorney’s fees, court costs, and all applicable collections expenses.

**Referrals**

Some insurance carriers may require you to obtain a written referral from your primary care physician for specialty services. We will only perform services and file claims for authorized services based on your insurance carrier’s guidelines. Payment for unauthorized services will be due at the time service is rendered.

**Attention USFHP members:**

**Per the insurer’s requirements, members MUST obtain a referral from their primary care provider in order for any urgent care visits to be covered. Per the insurer’s requirements, it is the MEMBER’S RESPONSIBILITY to obtain this referral, not the facility’s. I understand that if I do not obtain a referral from my primary care provider for today’s visit, the insurer will not cover today’s visit and the facility will bill me, I will be responsible to pay it.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Assignment of Insurance Benefits and Third Party Claims**

By signing this document, you authorize benefits from your insurance company to be made on your behalf to Drs ERgent Care LLC for services furnished to you by our providers. You also authorize release of your medical information necessary to process insurance claims on your behalf and payment in full will be expected prior to services being provided.

**Financial Attestation**

I understand that, regardless of my insurance status, I am ultimately responsible for my balance of any services provided to me. Payment due at the time or services are rendered which includes co-payments, deductibles, and co-insurance with my carrier. I have read both sides of this document and agree to the terms. I will notify the office of any changes in my personal and billing information.

**PATIENT NAME:** \_\_\_\_\_

**SIGNATURE OF PATIENT/ RESPONSIBLE PARTY:** \_\_\_\_\_