

Website Registration

Date: _____ Time: _____

Thank you for choosing UCR Health Centers as your healthcare provider. We are committed to providing quality medical care. We ask that you read, sign, and return this form to us prior to your treatment.

CONSENT FOR MEDICAL TREATMENT

Patient, or patient’s legal representative, agrees to the following terms of treatment:

I, the patient or authorized representative, consent to any examination, evaluation and treatment regarding any illness, injury or other health concern affecting me at any time I present at UCR Health Centers for care. These services may include, but are not limited to, laboratory procedures, x-ray examinations, and medical or surgical treatment or procedures.

I have read and understand this treatment agreement. I am the patient, the parent of a minor child, or the legally authorized representative of the patient and am authorized to act on behalf of the patient and to sign this agreement.

X Signature _____ Date: _____ Witness Signature: _____

PRINT NAME: _____ Patient Name: _____ Patient DOB: _____

FINANCIAL POLICY

UCR Health Centers is an urgent care center certified by the Department of Health Services in the state of Arizona. You agree that certain fees, charges, and service codes represent care provided in an urgent care center and do not represent the fees and charges provided in an office or emergency room.

- All patients must provide accurate and complete personal and insurance information prior to being seen by the doctor.
- Payment is required at the time of service and may be in the form of cash, debit, or credit card. **We do not accept personal checks.**
- UCR Health Centers may disclose all or part of a patient’s medical or financial records (including information related to alcohol and drug abuse, mental health diagnosis and treatment, HIV related or other communicable disease related information) to third parties to obtain payment for services provided.
- We will gladly file a claim with your insurance company. It is your responsibility to comply with any pre-determination or notification requirements of your insurance plan. Many of the services provided may be covered and paid for by your insurance company. Unfortunately, insurance companies do not pay for all services that the provider may deem appropriate.
- In all cases we require the guarantor, the person who is financially responsible, to be personally liable for all balances.
- We believe the fees we charge to be reasonable and customary fees for our region and specialty. If your insurance company uses a different fee schedule, you may be responsible for any balance remaining (**except workman’s compensation claims**).
- UCR Health Centers may charge reasonable fees for services related to your account including, but not limited to, returned check fees and medical record copies. If your account has not been paid in 30 days from the date of your first statement, we will submit your account to a collection agency and you will be responsible for any balance due AND a 30% collection charge. **You will receive ONE statement from UCR Health Centers only before your account is submitted to a collection agency.**
- Your personal information will be updated at the time of each visit to UCR Health Centers.
- We may collect a deposit on the charges you incur today toward your balance (e.g. co-pay, deductible, self pay) and bill you for any remaining balance. All bills are due upon receipt and will be sent to a collection agency after 30 days. You will receive a maximum of two billing statements before your account is sent to a collection agency.
- Federal laws require that we submit every claim to an insurance company accurately and report the exact services performed and the exact reason for performing them. We are not allowed to change information just so the insurance company can pay a claim.
- UCR Health Centers reserves the right to bill you for any administrative costs involved in collections of outstanding accounts.

This agreement will be valid for one year from the date it is signed. I certify that the information provided is true and accurate. I assign any payable benefits to be paid directly to UCR Health Centers and authorize them to submit a claim on my behalf. I understand that I am financially responsible for any non-covered service. I authorize UCR Health Centers to release any information required to process claims for my care and treatment. **I have read and understand the financial policy and agree to abide by it.**

X Signature _____ Date: _____ Witness Signature: _____

PRINT NAME: _____ Relationship to Patient: _____ Print Witness Name: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY RIGHTS

I have been made aware of UCR Health Centers’ privacy rights policy.

X Signature _____ Date: _____ Witness Signature: _____

PRINT NAME: _____ Relationship to Patient: _____ Print Witness Name: _____

May we call your contact numbers to leave a message regarding test results? YES NO