PNEUMONIA VACCINATION

Name: _____, _____
Last **First**

Date of Birth: _____/_____/_____ Phone Number: _____ SSN: _____-_____-_____

Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip Code: _____

HIPAA Patient Consent

By signing below, I have read and fully understand the Patient Consent for Use and Disclosure of Protected Health Information, rev. 7/ 2016. I consent and agree to all of its terms and conditions. I understand copies of The Urgent Care's full Notice of Privacy Practices are available on request.

Patient Responsibility and Financial Policy Clause

By signing below, I have read and fully understand The Urgent Care's Patient Responsibility and Financial Policy. I accept and agree to all of its terms and conditions. Specifically, I understand that I am responsible for any medical treatment and medical equipment not covered by my insurance plan or applied towards my copay, coinsurance, and/or deductible. These services include, but are not limited to: Injections (administration fee & medicine), IV treatments and fluids (initial IV treatment, hydration, medicine, etc.), and durable medical goods (crutches, walking boots, splints, slings, ace wraps, etc.) I understand that balances may be assessed interest and collection fees. I understand that any overpayments may remain as a credit balance on my account, to be applied to future charges, unless I request a refund. Credit balances remaining will be handled per the Patient Responsibility and Financial Policy may be assessed inactivity fees and/or processing fees if sent to the Louisiana Secretary of State LSA R.S. 9:151 et seq.

Consent for Treatment

By signing below, I understand that I have a choice to be seen at The Urgent Care versus the hospital Emergency Department, my primary care, or a specialist. I authorize The Urgent Care to provide medical treatment and services to me. I understand I am authorizing The Urgent Care to treat me while I seek care from The Urgent Care or until I withdraw my authorization in writing.

Patient Signature: _____ Today's Date: _____/_____/_____

OFFICE USE ONLY:

Forearm Administered: Right Left

Lot #: _____ Expiration Date: _____

Administered By: _____

Patient Signature: _____ **Date:** _____/_____/_____

I declare the above information is true. I authorize my insurance benefits to be paid to The Urgent Care. I understand that I am financially responsible for any charges that may not be covered by my insurance plan. I authorize my medical information to be released to my insurance company/ any of its affiliates for medical purposes.