EMURGENT CARE, LLC **Authorization Form**

**Please initial and sign at the bottom

Assignment of Benefits (Personal Medical, Worker's Comp, MVA)

X_____ I authorize the assignment of benefits of insurance and any overdue interest payments under the Medical Payments policy of Insurance with my insurance carrier or the responsible insurer to ***Emurgent Care, LLC*** for services rendered. *This also applies to Worker's Comp Insurance policies and the no-fault Policy Automobile Insurance, also known as Personal Injury Protection (P.I.P.) or Medical Payments.* The medical provider agrees to accept the irrevocable assignment of medical expenses.

Direction to Pay

X_____ I request that the payment authorized be made on my behalf. A photocopy of this assignment is to be considered as valid as an original. I understand that I am responsible for any applicable deductible, co-insurance, co-payments, or for any and all other services ***NOT*** covered by the insurance policy.

Card/Check on File Agreement

X_____ I agree to provide ***Emurgent Care, LLC*** or its designated payment agent with my debit/credit card or ACH information. I understand that my signature and payment information will be maintained on file digitally for future use by the practice. Card or ACH information will be obtained through a card swipe, manual entry from card, void check, or orally in person or over the phone. Information will be truncated or "tokenized" to help maintain the security of my payment information.

Release of Information

X_____ I hereby authorize ***Emurgent Care, LLC*** to furnish my insurance company or companies, or their representatives with any information contained in my medical record needed to substantiate payment of claims.

Acknowledgement of Receipt of Privacy Practices

X_____ We are required to present to you a copy of our Notice of Privacy Practices which states how we may use and/or disclose your health information. Please acknowledge that a copy was presented to you. You may ask for a printed copy to keep for your records.

Consent to Treat

X_____ I authorize and direct ***Emurgent Care, LLC***, as necessary to provide and perform medical care. I acknowledge that no guarantees have been made to me as to the outcome of the procedure(s) and/or treatment(s). I grant this consent without duress, confusion, or pressure from my provider and/or staff, associates, or colleagues.

Legal Representative or Patient Under 18

X_____ I represent that I am the legal representative of the member/patient identified and give my permission for member/patient to receive treatment. I will provide written proof when needed (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the member's/patient's behalf. Relationship: _____

Medicare Part B Lifetime Signature Authorization ***(Only for Medicare Insured Patients)***

X_____ I authorize any holder of medical or other information about me to release to the Social Security Administration or it's intermediary carriers or the billing agent of ***Emurgent Care, LLC***, 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 be made to the holder of this assignment on my behalf. I understand that I am responsible for any deductibles and co-insurances.

Patient's Name: _____

Patient/Legal Rep Signature: _____ Date _____