

Improving America's health, one patient at a time.

**Notice of
Privacy Practices**

Your name and signature below indicate that you have received a copy of Concentra's Notice of Privacy Practices on the date and time indicated. If you have any questions regarding the information in Concentra's Notice of Privacy Practices, you may contact Dona-Marie Geoffrion, Vice President and Privacy Officer for Concentra, at toll free 800-232-3550.

Name (please print): _____

 Signature: _____

Date and time Notice received: _____

**Urgent Care
Financial Policy**

Today you will be responsible for either full payment or your co-payment plus the cost of any other services not covered by insurance.

*If you have
insurance...*

If you have insurance, we will file today's charges with your insurance company. Before treatment, you must present the following at the front desk:

- Your insurance card
- Your valid drivers license or other accepted photo ID

If Concentra has a contract with your insurance company, you will be responsible for your co-payment and the cost of any services not covered by insurance. You may receive a bill from Concentra for any unpaid balance.

*If you do not
have insurance...*


If you do not have insurance coverage or Concentra does not have a direct contract with your insurance company, you will be required to pay in full for your visit today. You can expect to make a minimum initial payment of \$85 for a basic urgent care visit based on posted pricing in the center, which will be collected at your check-in.

- If your treatment requires more complex evaluations, labs, X-rays, or supplies, you will be charged for those in addition to the appropriate office visit fee. These fees will be collected after service and treatment have been provided.

**Release of
Medical Records,
Assignment of
Benefits,
Financial
Responsibility**

I authorize Concentra to submit claims to my insurance carrier as well as medical records needed to evaluate these claims for payment. I further authorize payment of benefits, otherwise payable to me, to be made payable to Concentra. I understand that I am financially responsible for all charges not covered by my insurance.

If my insurance company is not in Concentra's network or I have no insurance coverage, I understand that I am financially responsible for all charges and must make full payment today.

 Signature of Patient/Guardian: _____ Date: _____

**Authorization
and Agreement
for Medical
Treatment**

I give permission to Concentra Medical Centers to perform the medical and surgical processes, treatment, and/or procedures that the physician and other non-physician providers and assistants may deem to be necessary. In addition, I authorize Concentra Medical Centers to release any information obtained during the course of my examination and/or treatment to my health care insurer or other payer. I agree that I am financially responsible to Concentra Medical Centers for charges resulting from my receipt of such medical and surgical processes, treatment, and/or procedures.

 Signature of Patient/Guardian: _____ Date: _____