



Health Express Urgent Care Patient Consent

CONSENT TO TREATMENT

I voluntarily consent to receive medical and healthcare services provided by Health Express Urgent Care's physicians, employees, and such associates, assistants, and other healthcare providers, as deemed necessary. I understand that such services may include diagnostic procedures, examinations, testing, and treatment. I understand this facility may be a teaching environment and may have students involved in my care under appropriate supervision.

I understand that the practice of medicine is not an exact science and that no warranty or guarantee has been made to me regarding the outcome, result, or cure of my condition.

I acknowledge that my care may include diagnostic testing of varying complexity, including but not limited to laboratory testing, imaging, specimen collection, molecular testing, pathology services, and other procedures that may be performed onsite or referred to external facilities.

I authorize Health Express healthcare professionals—including physicians, physician assistants, nurse practitioners, technologists, and clinical staff—to provide or order any medically necessary evaluation, diagnostic testing, therapeutic procedures, and treatment based on their professional judgment and standard of care.

This consent applies to all services provided during this visit and any directly associated follow-up care related to this encounter. I understand that I have the right to ask questions and receive information about my treatment before consenting.

HEALTH INFORMATION EXCHANGE

I acknowledge that this facility may use health information exchange systems to electronically transmit, receive, and/or access my medical information, which may include, but is not limited to, treatments, prescriptions, laboratory results, medical and prescription history, and other healthcare information for purposes of treatment, payment, and healthcare operations.

RELEASE AND USE OF INFORMATION

I acknowledge that "protected health information" pertains to my diagnosis and/or treatment at Health Express Urgent Care, including, but not limited to, information concerning mental health conditions (excluding psychotherapy notes), substance use, or communicable diseases.

I authorize the use and disclosure of my protected health information for purposes of treatment, payment, and healthcare operations, including but not limited to billing, insurance claims processing, care coordination, quality assurance, and administrative activities as permitted by law.

SPECIMEN COLLECTION AND THIRD-PARTY SERVICES

I consent to the collection, handling, and analysis of specimens, including but not limited to blood, urine, swabs, or other biological samples. I understand that such specimens may be sent to third-party or reference laboratories for processing and analysis.

I acknowledge that these services may result in separate charges from entities other than Health Express Urgent Care and agree that I am financially responsible for those charges.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

In consideration for healthcare services provided, I understand and agree that I am financially responsible for all charges related to my care, regardless of insurance coverage, benefit determination, or payment by any third-party payer. This includes, but is not limited to, co-payments, co-insurance, deductibles, non-covered services, and any charges denied or not paid by my insurance carrier.

I acknowledge that services provided may include, but are not limited to, routine, specialized, and high-complexity diagnostic testing, including laboratory testing (including send-out or reference laboratory testing), molecular testing, pathology services, imaging, and other medically necessary procedures. I understand that such services may be determined necessary during or after my visit based on clinical findings.

I agree to be financially responsible for all such services, including those performed by third-party providers or laboratories, whether billed by Health Express Urgent Care or separately.

I hereby assign to Health Express Urgent Care's physicians and providers all rights, title, and interest in any insurance benefits otherwise payable to me for services rendered. I authorize direct payment from Medicare, Medicaid, and/or my insurance carrier to Health Express Urgent Care.

I certify that all information I have provided for purposes of insurance billing and payment is true, accurate, and complete. I understand that I am responsible for updating any changes to my insurance information.

I understand that if my account is referred for collection, I may be responsible for reasonable collection costs, including fees permitted by law.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered or provided a copy of Health Express Urgent Care's Notice of Privacy Practices ("Notice"), which describes how my health information may be used and disclosed. I understand that Health Express Urgent Care reserves the right to change this Notice at any time and that a current version is available upon request or at www.HealthExpressUC.com.

ACKNOWLEDGMENT AND SIGNATURE

Print Patient Name _____

Signature of Patient or Parent/Guardian _____

Date _____