JAYHAWK HEALTHCARE, LLC
dba PROMPTCARE and Lawrence Occupational Health Services
CONSENT, ASSIGNMENT, RELEASE FORM

Patient Name: First ________________________________ Last ___________________________________

Date of Birth ____________________ Reason for your visit today:_______________________________________

Have you been treated here in the last three years? Yes No

Is this Work related? Yes No Is this visit for an Auto Accident? Yes No

The examination and treatment received at JAYHAWK HEALTHCARE, LLC dba PROMPTCARE and LAWRENCE OCCUPATIONAL HEALTH (hereafter referred to as "PROMPTCARE") is on an urgent basis only and is not a substitute for complete medical care. It is important that you follow-up as instructed. PROMPTCARE is not a 24-hour facility. If you notice any worsening of your symptoms, promptly call your primary care doctor or go to the nearest emergency room. We file insurance as a courtesy to the patient. Benefits depend on what you or your employer negotiated with the insurance carrier. *It is impossible for us to know the status of your individual policy. This is your responsibility.*

CONSENT FOR MEDICAL TREATMENT– I voluntarily present for treatment and consent to my physician and whomever they may designate as their assistant, associate, treating physician and patient care staff to provide my care. Such care may include, but not be limited to, diagnostic procedures, psychotherapeutic treatment, other treatments and medications, pathologic and radiological evaluations and procedures considered advisable in my diagnosis, treatment, and course of care. I acknowledge that no guarantee can be made or has been made as to the results of treatments or examinations at PROMPTCARE.

RELEASE AND USE OF PATIENT INFORMATION– I authorize the release of my medical records, information, treatment and advice, and specific health information to:

(1) AN EMPLOYER/AGENT who requested the services (including history, physical, laboratory and diagnostic tests, and screening for the presence of drugs, alcohol or other substances)

(2) INSURANCE COMPANY or other third party payer and their agents as well as any review organization or government agency for the purpose of determining eligibility, available benefits and obtaining payment for services provided

(3) EDUCATIONAL OR SCIENTIFIC INSTITUTIONS, authorized health care professionals in training, internal quality improvement, risk management and legal counsel when it is judged that my ongoing medical care, medical research, quality improvement, healthcare education or science will benefit; for any purpose authorized by law

(4) TREATING PHYSICIANS on staff at PROMPTCARE, their agents and allied health professionals; to another health care facility upon direct transfer and to my attending consulting, referring and/or primary care physicians for follow up care. I understand that if I refuse to authorize access to my records for coordination of care, my treatment could be adversely affected. I understand this information concerning medical care, advice or treatment may include history and physical/diagnosis/laboratory and diagnostic testing/specific information concerning alcohol abuse/mental health/drug abuse/human immune-deficiency virus/hepatitis/or other infectious diseases. I understand that I have the right to revoke this authorization. If my revocation prevents payment or reduces payment for services received, I become responsible for payment.

ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT GUARANTEE– In consideration of services provided by PROMPTCARE, I hereby assign and transfer to PROMPTCARE any and all rights, which I have against insurance companies governmental agencies, or third party payers, for payment of charges for services provided by PROMPTCARE to me or to one of my dependents.

RECEIPT OF HIPAA PRIVACY NOTICE– I acknowledge the Notice of Privacy Rights was made available to me, with detailed information about how PROMPTCARE may use and disclose my protected health information. I understand that PROMPTCARE reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

I acknowledge the above, give consent, authorize release, and assign benefits to PROMPTCARE.

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Print Name of Patient (or Consenting Parent/Guarantor if under 18)

____ ________________
Signature of Patient (or Consenting Parent/Guarantor if under 18) *Date*

FINANCIAL RESPONSIBILITY

I understand that I am responsible for and will pay for all services rendered on my behalf. In consideration of service to be provided, I agree to pay PROMPTCARE in accordance to the regular rates and terns of PROMPTCARE. I further agree to pay the account in full upon receipt of my billing statement. If my account is placed for collection an additional 18% interest accrued daily will be added to my balance and if my account is placed for litigation, I will be responsible for the costs of collection including but not limited to attorney's fees and court costs.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Patient is responsible for the costs of all services rendered regardless of whether or not the patient may have insurance coverage. Payment is the responsibility of the patient.

I understand a fee of $30.00 will be charged to my account for any check returned for any reason. If my account is placed for collection 18% interest will be charged on my balance and I will be responsible for the costs of collection including but not limited to attorneys fees and court costs.

I hereby assign all medical/surgical benefits to PROMPTCARE and understand that I am financially responsible for all charges. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

You expressly consent and agree that, in order to discuss or service your accounts(s) (the "Accounts ") or to collect amounts you may owe, PROMPTCARE, and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively, "We") may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contact you by sending text messages, emails, using any e-mail address you provide to us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

CREDIT CARD/DEBIT CARD AUTHORIZATION

PROMPTCARE submits claims to insurance carriers as a convenience to all our patients. At this time we request authorization to balance bill a major credit card or debit card to cover amounts determined by your insurance to be your responsibility.

Upon receipt of an explanation of benefits from your insurance carrier any unpaid portion of your claim up to $150 will be billed to your credit card or debit card. Amounts due in excess of the $150 will be billed to you. Should insurance pay in full, your account will not be charged.

All credit card/debit card information will remain absolutely confidential and securely stored by First Data. PROMPTCARE will not store any banking account data.

Our billing department will send you an email approximately seven days before prior to charging your credit/debit card for the remaining patient responsibility. Please legibly print the email address below where you would like to receive this notification. If this email address is not valid you may not receive the notification and your card will still be charged.

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Responsible Party/Cardholder's Authorization Signature *Date*

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EMAIL ADDRESS