HASTINGS CONVENIENT CARE, PC

AUTHORIZATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION:
All professional services rendered are charged to the patient; necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees regardless of insurance coverage. All services provided to you as a patient of HASTINGS CONVENIENT CARE, PC (HCC, PC) are payable at time of service and are the sole responsibility of you "the patient" and/or guarantor of "your children". I hereby authorized HCC, PC to furnish insurance companies or their representatives' information concerning my (dependents) illness and treatments and i hereby assign to HCC, PC all payments for medical services rendered by myself or my dependents. i understand that i am responsible for any amount not covered by insurance. i hereby authorize and release the provider and whomever he/she may designate as his/her assistant to administer treatment, physical exam, x-ray studies, laboratory procedures, medical care or any clinical service that he/she deems necessary in my case, and i further authorize him/her to disclose all or part of my (patients) record to any person or corporation which is or may be liable under contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic charge, including but not limited to hospital or medical services company, insurance company, workers compensation carriers, welfare funds, or the patient's employer.

PATIENT INFORMATION CONSENT:
I understand that HCC, PC may need to use and disclose information about my health or medical problems for the purpose of arranging, conducting, or referring my treatment; for obtaining payment for services, and for the purpose of operating the practice. I consent to the use of my information for the purpose of treatment, payment and health care operations. HCC, PC may provide vaccination information to the State Vaccine Registry (**NESIIS**) via electronic integration. I understand that my consent is not needed if the law requires HCC, PC to report some aspect of my protected health information to a government agency (For example, suspected abuse, communicable disease and potential bodily harm to myself or others). I understand that I have the right to review HCC, PC privacy notice to request restrictions be put on the use of my information, and to revoke my consent at a later date. I understand that if I withhold consent for the use of my information for the purpose of treatment, payment or operations, HCC, PC may refuse to undertake my care. I, the undersigned, hereby consent to the following treatment: administration and performance of all treatments administration of any needed anesthetics, performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, use of prescribed medication, performance of diagnostic procedures/tests, cultures, biopsies and surgery, performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees. I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. I understand and that my medication history will be retrieved for the last 13 months including medications I have filled through my prescription drug plan.

FINANCIAL AGREEMENT
I agree, whether I sign as the patient or as the legal representative of the patient that in consideration of the services rendered to the patient that I individually obligate the patient and myself to pay the account. In the event of a payment being made with a check that is returned from the bank due to insufficient funds there will be a $25 NSF check fee and payment must be made with either cash, money order or cashier's check made out to HCC, PC.

MEDICARE PATIENTS
I authorize to release medical information about me to the Social Security Administration or its Intermediaries for my Medicare claims. I assign the benefits payable for services to HCC, PC.

NON-COVERED MEDICARE
The Medicare program has certain patient exclusion from coverage including, but not limited to, routine diagnostic work up and some routine physical examinations. If your medical chart indicates your office visit is for any of the above and for which no Medicare benefits are allowable, please be advised that all charges incurred during your office visit will be **your financial responsibility.**

EXPRESSLY CONSENT AND AGREE THAT
In Order to discuss or service your account(s) or to collect amounts you may owe, Hastings Convenient Care, P.C. 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.

HIPPA ACKNOWLEDGEMENT
The undersigned does hereby acknowledge that he/she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPPA and has been advised that a full copy of the this office's HIPPA Compliance Manual is available upon request.

THE UNDERSIGNED DOES HEREBY CONSENT TO THE USE OF HIS/HER HEALTH INFORMATION IN A MANNER CONSISTENT WITH THE NOTICE OF PRIVACY PRACTICES PURSUANT TO HIPPA, THE HIPPA COMPLIANCE MANUAL, STATE LAW AND FEDERAL LAW.

_____ _____
Signature of patient or authorized person **Date**

_____
Witness

HASTINGS CONVENIENT CARE, PC

Credit\Debit Card Pre-Authorization

Hastings Convenient Care P.C. submits patient claims to insurance carriers as a courtesy to our patients.

OPTION A		**OPTION B**
Copay or $50 up front **AND** Credit/Debit card preauthorization	**OR**	$100 minimum cash payment up front

Check mark one option below for future balances

Auto charge all ⬭ Auto charge this visit ⬭ No auto charge ⬭

I hereby authorize Hastings Convenient Care P.C. to charge any and all outstanding balances, after insurance company reimbursement or denial, to my credit\debit card. I understand that I will not receive a statement if there is no balance due after processing my card for payment.

Patient Name:_____ **Date of Birth**_____

Contact Email Address:_____@_____

Authorization Signature: _____**Date:**_____

**We will attempt to contact you via email 7 days prior to debiting this card. At that time you have the option to submit a payment in a different form by contacting our billing department at 1-402-463-6300. Hastings Convenient Care, P.C. is not responsible for any overdraft fees that may occur due to this automatic payment. It is the sole responsibility of the cardholder to contact the billing office if this card is not to be used for balances incurred. Hastings Convenient Care P.C. does not store banking account information. All credit\debt card information is stored securely and confidentially by FIRST DATA per your request above.