



Notice of Privacy Practices

Your name and signature below indicate that you have received a copy Inspira Urgent Care, PC's Notice of Privacy Practices on the date that you indicated.

Patient Name (please print): _____

Medical Care/Treatment Financial Policy:

Unless you are here for employer paid services, you will be responsible for either full payment or payment as indicated by your insurance plan.

If Inspira Urgent Care, PC has a contract with your insurance company we will file today's charges with that insurance company. You will be responsible for today's co-payment or co-insurance, and the cost of any services that are not covered by insurance. You may receive a bill from Inspira Urgent Care, PC.

If you do not have Insurance coverage OR Inspira Urgent Care, PC does NOT have a contract with your insurance company; you will be required to pay in FULL for your visit today. You can expect to pay an initial payment for medical care/treatment based on pricing, which will be collected at check-in.

*** If your treatment requires more complex evaluations, lab tests, vaccines, medication, 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 , Assignments of Benefits, Financial Responsibility :

I authorize Inspira Urgent Care PC to submit claims to my insurance carrier, as well as medical records needed to evaluate these claims for payment. I understand that if my employer is responsible for paying all or part of this claim, they will receive the medical information needed to pay this claim and I authorize release of this information. I further authorize payment of benefits, otherwise payable to me, to be made payable to Inspira Urgent Care, PC.

I understand that I am financially responsible for all charges not covered by my by insurance.

***If my insurance company is not in Inspira Urgent Care, PC's network or I have no insurance coverage, I understand that I am financially responsible for all charges and must make FULL payment today ***

Consent for Medical Treatment

I give permission to Inspira Urgent Care PC 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 Inspira Urgent Care, PC to release any information obtained during the course of my examination and /or treatment to my health care insurer or other payer.

I authorize the following people to receive my personal health information (labs, test results, etc.)

Signature of Patient/Guardian: _____ Date: _____