

# CONSENT, ASSIGNMENT, RELEASE FORM



10015 N. Ambassador Dr. • Suite 100  
Kansas City, MO 64153  
**816-595-4000**

**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 The Urgency Room.

**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 who requests services (including history, physical, laboratory and diagnostic tests, and screening for the presence of drugs, alcohol or marijuana)
- (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 The Urgency Room, 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 The Urgency Room, I hereby assign and transfer to The Urgency Room any and all rights, which I have against insurance companies, governmental agencies, or third party payers, for payment of charges for services provided by The Urgency Room to me or to one of my dependents. I understand that I am responsible for and will pay the portion of my bill not covered by insurance companies, governmental agencies or third party payers. In consideration of services to be provided, I agree to pay The Urgency Room in accordance with the regular rates and terms of The Urgency Room. I further agree to pay the account in full upon receipt of my billing statement unless payment arrangements are made with The Urgency Room. I authorize said payments to be applied to any unpaid The Urgency Room balance for which I am responsible. If my account is placed with a collection agency, an additional 25% will be added to my balance.

I give consent, authorize release, and assign benefits to The Urgency Room: \_\_\_\_\_  
*Patient/Guarantor signature*

## RECEIPT OF HIPAA PRIVACY NOTICE —

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how The Urgency Room may use and disclose my protected health information. I understand that The Urgency Room reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

\_\_\_\_\_  
*Printed Patient name*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of Patient or Parent/Guardian*

Office use only: (To be completed only when patient declines to sign acknowledgment):

\_\_\_\_\_ Check here if patient declined to sign acknowledgment \_\_\_\_\_ Staff initials \_\_\_\_\_ Date

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION (VERBAL AND COPIES) TO MEMBERS OF YOUR FAMILY OR OTHER INDIVIDUALS** — I accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1966, in order for your physician or the staff of The Urgency Room to give copies of and/or discuss your condition/exams/procedures/x-rays with members of your family or other individuals that you designate other than your *primary care doctor or specialist*, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

I authorize The Urgency Room to release any and all information (including verbal information, copies of x-rays and medical paperwork) concerning my medical care to the following individuals:

\_\_\_\_\_  
Name (please print) Relationship Phone Number

\_\_\_\_\_  
Name (please print) Relationship Phone Number

\_\_\_\_ I DO NOT authorize The Urgency Room to release any information concerning my care to any individual.

\_\_\_\_ I authorize The Urgency Room to leave a detailed message and/or confirm appointments on my home answering machine.

Voice mail phone number: \_\_\_\_\_

\_\_\_\_ I DO NOT authorize The Urgency Room to leave a detailed message or confirm appointments on my home answering machine.

\_\_\_\_\_  
Your signature

\_\_\_\_\_  
Date

**AUTHORIZATION TO DISCUSS FINANCIAL INFORMATION** - In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1966, we must obtain your authorization to discuss financial information with members of your family or other individuals that you designate other than insurance companies or third party payers and their agents.

I authorize The Urgency Room to verbally discuss financial information with:

\_\_\_\_\_  
Name (please print) Relationship Phone Number

\_\_\_\_\_  
Name (please print) Relationship Phone Number

\_\_\_\_\_  
Your signature

\_\_\_\_\_  
Date