

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Reason for Visit/Symptoms: \_\_\_\_\_

Pharmacy: \_\_\_\_\_

## Walk-In Clinic Consent

### Consent to Treat

I hereby give authorization to all the physicians and staff at South Alabama Family Care to treat myself and/ or my minor child. I understand that there are no guarantees regarding the result of treatment and/or examinations.

Initial: \_\_\_\_\_

### Electronic Communications

SAFC, and/or our agents may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using the email address you provide to use.

Initial: \_\_\_\_\_

### Financial Responsibility

Payment is due at the time of service. I understand I will be expected to pay any deductibles, co-payments, and fees at the time of any office related service. I will be responsible for any patient balances after insurance has been filed. I understand that South Alabama Family Care has the right to refer my account to an outside collection's agency after a period of 90 days. I hereby give authorization for payment of insurance benefits to be made to South Alabama Family Care for services rendered. I understand that I am financially responsible for all charges whether they are covered by insurance or not. In case of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare facility to release all information necessary to secure payment of benefits and that a photocopy of this agreement shall be as valid as the original

Initial: \_\_\_\_\_

### Notice of Rights, Responsibilities, and Privacy- Summary

- SAFC can/will use my health information for the purpose of medical treatment, to obtain payment for treatment, and SAFC's health care operations.
- SAFC can/will also use and share my health information as required/permitted by law.
- I am responsible for following instructions about care and treatment and understanding the consequences if I do not follow them as directed by the clinical staff.
- I am responsible for giving complete and accurate information about my health and my medical history, as it is vital to my medical treatment.

### Acknowledgement of Receipt for the Privacy Practices/ Patient Rights

I acknowledge that the South Alabama Family Care's Notice of Privacy Practices and the Patient Rights are posted for view in the lobby and listed above, and printed copy is available upon request from the front desk staff. The notice explains in detail my individual rights and how I may exercise these rights.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Patient  Legal Guardian  Other \_\_\_\_\_