1305 West Parkwood, Suite 101
Friendswood, Texas 77546
Tel: 281-648-4800/ Fax:281-648-4803

Patient Financial Responsibility Form

Thank you for choosing Friendswood Urgent Care. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the cost of his/her own treatment and care.
- We are pleased to assist you by billing our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.
- Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatments not covered by their insurance plan. Payment is due at the time of service and for convenience, we accept cash and most major credit cards at our office.
- Patients may incur, and are responsible for the payment of additional charges at the discretion of Friendswood Urgent Care. These charges may include (but are not limited to):
    - Charge for the copying and distribution of patient medical records($20 for first 10 pages .25 per page thereafter)
    - Charge for extensive forms completion ($20)
    - Any cost associated with collection of patient balances
- If there is a remaining balance on your patient account and several attempts have been made to collect monies owed, Friendswood Urgent Care reserves the right to charge an amount up to $500 to the credit card on file to settle the outstanding debt.

Patient Authorizations

- By my signature below, I hereby authorize Friendswood Urgent Care and the physicians, staff and hospitals associated with Friendswood Urgent Care to release Medial and any other information acquired in the course of m examination and/or treatment (with the exceptions stipulated below) to the necessary insurance companies, third party payers, and/or other physicians and/or healthcare entities required to participate in my care. By checking one or more of the following boxes, the health information I authorize to be released may include any of the following:
    - Diagnosis, evaluation, and/or treatment for alcohol and/or drug abuse
    - Records of HTLV-III or HIV testing (AIDS test) result, Diagnosis, and/or treatment
    - Psychiatric and/or psychological records or evaluation and/or treatment for mental, physical and/or emotional illness including narrative summary, test, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluations
- By my signature below, I hereby authorize assignment of financial benefits directly to Friendswood Urgent Care and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.
- By my signature below, I authorize Friendswood Urgent Care personnel to communication by mail, voicemail, and/or email according to the information I have provided in my patient registration:

_____ _____
Signature of Patient or Guardian Date

Waiver of Patient Authorization : (Self Pay)

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

_____ _____
Signature of Patient or Guardian Date