OnSite Care
Affordable Healthcare at Work

Authorization for Medical Treatment and Patient Services Agreement

Patient Name: _____ ("Patient") Birth Date: ____/____/_____

CONSENT FOR TREATMENT
I voluntarily consent to care and treatment of the Patient by OnSite Care and its affiliated physicians, practitioners, and staff, including but not limited to outpatient medical, surgical, nursing, and therapeutic care; diagnostic, laboratory, and radiological tests and procedures; administration of pharmaceuticals or anesthesia; and such other care as deemed reasonably necessary or advisable by the attending physician, practitioner or staff member. I consent to taking photos, videos, or other recordings of the Patient for purposes of treating the Patient or for OnSite Care's quality assurance activities. If OnSite Care personnel suffer a needle stick or are exposed to blood or body fluids, I consent to testing the Patient for any bodily fluid-borne disease for the protection of OnSite Care personnel. I authorize OnSite Care to view my prescription history through external sources. I understand and agree that the practice of Medicine is not an exact science and that no guarantees have been made to me regarding the results of the Patient's care or treatment at OnSite Care.

PERSONS FOR WHOM PRACTICE IS NOT LIABLE
I understand that OnSite Care is only responsible for the acts of its employees acting within the scope and course of their duties. I understand that persons who are not employed by OnSite Care may be involved in my care or treatment, including but not limited to other practitioners, laboratories, diagnostic testing facilities, contractors, vendors, product technicians, etc. I understand that OnSite Care is not liable for the acts or omissions of non-employees or OnSite Care employees acting outside the course and scope of their duties.

ADVANCE DIRECTIVES
Has the Patient executed an advance directive?
[ ] Living Will
[ ] Power of Attorney for Health Care
[ ] POLST
[ ] Other (describe): _____

I understand that the Patient or representative may execute or modify an advance directive at any time.

PATIENT CONTACT AND COMMUNICATION
I request that OnSite Care communicate with me at the following addresses or numbers. I understand that communications via text or e-mail may not be secure. OnSite Care utilizes a secured patient portal under which some messaging and record-sharing may occur.

[ ] Phone: (_____) _____-_____

[ ] Text: (_____) _____-_____

[ ] E-mail _____

NOTICE OF PRIVACY PRACTICES
I acknowledge that I have been given a copy of OnSite Care's Notice of Privacy Practices on this or a prior occasion. I may obtain a copy of the Notice of Privacy Practices upon request. [Please Initial] _____

PATIENT RIGHTS AND RESPONSIBILITIES
I have received or been offered a copy of the Patient Rights and Responsibilities. I agree to comply with the Patient Responsibilities.

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PAYMENT
I agree that I am responsible for any co-payments, deductibles or other charges for services that are not covered or paid by insurance, government programs, or other payers, except as prohibited by applicable law or any agreement between my insurance company and OnSite Care. I agree to make such payments according to OnSite Care's regular terms of payment. I agree to cooperate with OnSite Care in submitting claims to entities from which payment may be obtained, including any government program, insurance company, or other third parties.

I understand that any quoted charges for services rendered and/or insurance benefits available are estimates based on the information available at the time. Estimates may vary significantly from the final charges based on a variety of factors, including but not limited to the course of treatment, Patient compliance with instructions, provider practices, and the necessity of providing additional items and services. I understand that I will be responsible for charges for services rendered. I agree that any overpayments collected for Patient's admission or treatment on this occasion may be applied directly to any delinquent account of Patient. I understand that there will be a $20.00 fee for any check that is not honored by my financial institution and that I could be subject to a payroll deduction and/or collection fees up to 40% for any outstanding balance and I provide consent for OnSite Care and any collection agency to contact me directly regarding any outstanding balance.

ASSIGNMENT
I assign to OnSite Care any payments or other benefits to which I may be entitled from any government program, insurance company, or other entity that is or may be liable for costs associated with the Patient's care. I agree that this assignment will not be withdrawn at any time until the account is paid in full.

PERSONAL PROPERTY
I understand and agree that OnSite Care does not assume any responsibility for loss or damage to my personal property brought to any OnSite Care facility. I am solely responsible for securing such property.

TOBACCO USE POLICY
OnSite Care clinics are tobacco-free facilities. I understand that I am not permitted to use tobacco products in OnSite Care health facilities.

I hereby certify and state that I have read, and fully and completely understand the above Authorization for Medical Treatment and Patient Services Agreement ("Authorization"); that any questions I have were answered; and that I sign this Authorization knowingly, freely, and voluntarily.

_____ _____
Signature of Patient or Legal Representative Date / Time

_____
Relationship to Patient