WESTCARE CLINIC

3000 Limited Lane NW
Olympia, WA 98502
(360) 357-9392
Fax (360) 853-2244

PATIENT AUTHORIZATION / ASSIGNMENT OF BENEFITS

(PLEASE READ AND SIGN THIS DISCLOSURE)

This **walk in medical clinic** is open to serve those patients either not having a family physician or whose physician is not presently available. It is designed to care for problems which will **NOT** require hospitalization - problems other than those will be referred to another physician. This office is closed most major holidays. A physician from this office will **NOT** be available after hours. Westcare staff will make every effort to arrange continuing care when necessary.

I understand that due to the limited office hours and availability of the physician who will be seeing me today, that neither the physician nor Westcare Clinic, Inc., are able to accept responsibility for my continuing care of this problem or of any future medical problems which I may develop, i.e./ **WESTCARE CANNOT ASSUME RESPONSIBILITY OF BEING MY FAMILY PHYSICIAN. I MUST SEEK CARE AT THE OFFICE IF ANOTHER PHYSICIAN OR AT A HOSPITAL EMERGENCY ROOM FOR ANY CONTINUING OR NEW MEDICAL PROBLEMS WHEN WESTCARE IS NOT OPEN.** I further understand that if hospitalization is deemed necessary that I will be referred to another physician for this care.

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

I accept responsibility for all charges incurred during my care at Westcare Clinic. I understand that payment is required at the time of service. (Westcare will automatically bill contracted insurance carriers -- our list of contracted insurance carriers is posted in our lobby.)
I further understand that I am responsible for understanding the benefits of my insurance plan and for obtaining any referrals required by my insurance company.
I also understand and agree that I am financially responsible for any balance of my bill not covered by my insurance carrier.
STATEMENTS: A monthly statement is issued for any balance owing (except for any delinquent account which will have the applicable late fee added before assigning to collection). The balance on the statement is due and payable when rendered.
LATE FEE: A $10.00 LATE FEE (subject to change) is added each month that a payment is not received (Effective 07/01/07)
DELINQUENT/COLLECTION ACCOUNTS: Delinquent accounts may be referred to a collection agency.
RETURNED CHECKS (NSF or STOP PAYMENT): A return check fee of $25.00 will be added to the amount owed, and any discounts received at the time of service will be added back to the balance.

➤ I understand that I will receive and additional bill further charges are found when my chart is audited.

ASSIGNMENT OF BENEFITS

I hereby assign all medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan to issue payment check(s) directly to Westcare Clinic, Inc., PS for medical services rendered to me or my dependents. I understand that I am responsible for any amounts not covered by my insurance, and for any amounts that are not regulated by provider contract or government or state health insurance coverage.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Westcare Clinic to furnish and/or release any information necessary to insurance carriers concerning my medical problem and treatment to process my insurance claim for this and any subsequent visits. This authorization will remain in effect until revoked by me in writing. I hereby authorize Medicare to furnish to the above named Clinic any information regarding my Medicare claims Title XVII of the Social Security Act. I further authorize release of my medical records for this and any future visits to any physician or hospital where I might seek continuing care for this or any future problem. A photocopy of this authorization and assignment is to be considered as valid as the original.

LABORATORY AND X-RAY WORK:
I UNDERSTAND AND AGREE THAT ALL LABORATORY AND X-RAY WORK THAT IS DONE WHILE AT WESTCARE WILL BE BILLED SEPARATELY.

I have read and understand the contents of this disclosure, and I agree to abide by these policies. I have had the opportunity to have my questions answered.

Patient/ Responsible Part Signature: _____

If not signed by patient, please indicate relationship to patient (e.g. spouse)

WCC INITIALS: _____ **DATE:** _____

Revised 9-2-11