Preferred Urgent Care
1450 W. Grand Parkway South
Suite M
Katy, TX 77494
281.916.1444

Notice of Privacy Policies

For Use and Disclosure of Protected Health Information (As required by HIPAA)

1. I hereby give my consent for Preferred Urgent Care to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). Please refer to our Notice of Privacy Policies detailed below for a more complete description of such uses and disclosures.
2. Preferred Urgent Care's Notice of Privacy Policies has been made available to me and I have the right to a copy, if I so desire. Preferred Urgent Care reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Preferred Urgent Care at 1450 W Grand Pkwy South, Suite M, Katy, TX 77494.
3. I have the right to request that Preferred Urgent Care restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.
4. With this consent, Preferred Urgent Care may contact me in reference to any items that assist the practice in carrying out TPO, such as appointment reminder calls/texts/emails, patient statements, insurance items, and laboratory results among others. Preferred Urgent Care may use phone, text, voicemail, e-mail or U.S. mail to contact me regarding such information.
5. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, or later revoke it, Preferred Urgent Care may decline to provide treatment to me.**

Acknowledgement of Receipt of Notice of Privacy Policies

I hereby acknowledge receipt of the Notice of Privacy Practices from Preferred Urgent Care (The covered entity) pursuant to HIPAA and have been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information. I understand that the practice has reserved a right to change its privacy practices that are described in the notice. I also understand that a copy of any revised notice can be provided to me or made available upon written request.

Financial Policy

In order to provide high-quality healthcare services, it is very important for a practice to stay financially viable.

1. Payment is due at the time of service unless arrangements have been made in advance. We accept cash, Visa, Master Card and American Express. We reserve the right to accept checks for our established patients. For returned checks, a fee of $25 will apply.
2. Your Health plan is a contract between you and your Insurance Company. Health plans vary widely in terms of benefits and coverage options, and in some instances, your financial responsibility may not be evident until we receive a response from the insurance company. You will be responsible for Co-pay, Co-insurance, and Deductible and uncovered charges, as applicable. The co-pay amount paid at the time of service is only an estimate of the patient's responsibility.
3. We bill and file claims with the contracted insurance companies. If your insurance company does not pay the clinic within a reasonable time (30-40 days), we will contact you for payment.
4. The services rendered may not be covered by your health plan. If the insurance company determines a service as "not covered", you will be responsible for all charges. If it is later determined that your coverage was not active on the day of the service, you will be responsible for all charges.
5. The billed charges from the clinic will be due within 30 days of the billed date. If you are unable to pay, please call the office to set up a payment plan or an alternate arrangement. If we do not get a response from you after multiple contact attempts, your case may be referred to a collection agency.
6. By signing this disclosure, you authorize payment directly for X-RAY and other ancillary services. You may incur additional charges as a result of these ancillary services. Patient acknowledges that X-RAY and other ancillary services are additional charge(s) for which our clinic may not be in contract with an insurance company. Patient accepts responsibility for such charges and agrees to pay all charges associated with such services.

Consent for Medical Care, Treatment, & e-Prescribe

1. I understand that my health condition may require diagnosis and treatment. I hereby voluntarily consent to such treatment, services, and procedures as ordered by the healthcare provider, his/her consultants, associates and his/her assistants, or his/her designees. I also understand healthcare providers in professional training programs may be among the individuals who provide care to me.
2. I authorize the providers at Preferred Urgent Care and their assistants/designees to discuss my medical history, diagnosis, treatment and prognosis as provided in the notice of privacy practices. I have the right to add anyone or any organization that I do not wish to have my medical information by requesting in writing at any time.
3. I understand there are times when the law allows the provider and their assistants/designees to release information regardless of whether or not I give my consent as outlined in the notice of privacy practices. For example, Preferred Urgent Care may release information to doctors, nurses and others who provide me with health care or are prospective health care providers; to government agencies as authorized by law to insurance companies or others who are responsible for paying my medical bills; or to a court of law that issues a subpoena or court order. I understand this information may be released either orally or in written document form.
4. NO GUARANTEE: I acknowledge that the practice of medicine is not an exact science and that the providers at Preferred Urgent Care have made no guarantees or warranties to me as to the result of treatments or examination.
5. I hereby authorize Preferred Urgent Care to release any information acquired in my examination or treatment necessary to process my insurance claims. I release Preferred Urgent Care and its associates from all legal responsibility that may arise from the act I have authorized. I request payment under the medical Insurance program be made directly to the provider of service on any unpaid bill for services provided. I permit a copy of this authorization to be used in place of the original.
6. By signing this consent form, I am agreeing that Preferred Urgent Care can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purpose. Understanding all of the above, I hereby provide informed consent to Preferred Urgent Care to enroll me in the e-Prescribe Program.