CONSENT TO MEDICAL TREATMENT

I, the undersigned am the patient, or the patient's duly authorized representative, and do hereby voluntarily consent to and authorize medical care and treatment by the physicians, nurses, practitioners, AEMTs, paramedics, medical assistants, and or physician assistants or nurse practitioners of ERgent Med Prime, ERgent Med-1, ERgent Med Prime, LLC, and ERgent Med-1, LLC and any ERgent Med facility, along with their employees participating in my care. Such care may include, but not be limited to, diagnostic procedures, other treatments and medications, and procedures considered advisable in my diagnosis, treatment, and course of care. acknowledge that no guarantees can be made or have been made as to results of treatments or examinations. I will provide all necessary information related to my healthcare needs that may affect the treatment I may receive, including but not limited to: past medical history, past and current medications, and current medical issues. I understand that if I do not provide all necessary information pertaining to my current health, I will not hold the providers or the other employees of ERgent Med liable for any adverse reactions. With my consent, ERgent Med may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment, and healthcare operations. Please refer to the ERgent Med Notice of Privacy Practices for a more complete description of such uses and disclosures. With my consent, ERgent Med may call my home or other designated locations and leave a message or voicemail or in person in reference to any item that assists the practice in carrying out treatment, payment, or other healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and diagnostic results.

NON-COVERED SERVICES: I am visiting the doctor today as indicated above. I acknowledge that **(1)** if I provide false information with regard to my insurance coverage, **(2)** if the services provided are not a covered benefit of my insurance plan, **(3)** if I am not a covered by this, or any other insurance plan, **(4)** if I present any insurance card with outdated or inaccurate information of if I have an HMO insurance but am not a member of ERgent Med or **(5)** if insurance denies payment for any reason, I acknowledge that I will be responsible to pay the cost of the doctor office visit and all other charges related to the visit. **You are responsible for informing us of any changes in coverage.**

NOTICE OF DISCLAIMER: This shall serve as notice that NOT all medical services are available or performed at ERgent Med Facilities. Services that are deemed necessary for the treatment or diagnosis of the patient and determined by our providers as necessary or in the best interest of the management of the patient's condition and any services that may be required at other specialized facilities outside of any ERgent Med locations are not part of or billed from ERgent Med facilities or care centers or areas. Any emergency care that the attending physician or mid-level provider believes should, in the best interest of the patient, by provided by another facility, will not be the financial responsibility of ERgent Med. Any medical transport facility that is felt to be medically necessary to transport patient to a facility for a higher level of care and to reduce medical risks that could occur during transportation to another facility are not the financial responsibility of ERgent Med. Any referral to another specialty service or facility will be done in the best interest of the patient and ERgent Med has no financial interest in referral facilities or specialist referral. Patients are expected to follow up with their own primary care physicians for continued medical management unless otherwise noted by the ERgent Med Care Provider(s). ERgent Med in no way acts or represents itself as a primary care provider unless the patient has formally established with an ERgent Med provider by scheduling an appointment and signing an agreement to enter a primary care provider and patient relationship with an ERgent Med provider. Any other type of services will be considered to be urgent care services, including any walk-in visit that is not formally scheduled at least 24 hours in advance of a primary care appointment date.

This authorization and understanding of notice of disclaimer remain in effect until either party provides a statement of cancellation in writing. I understand that ERgent Med will request that I review the Consent to Medical Treatment policy on an annual basis and will require an updated signature of authorization on an annual basis, however, to ensure that I am aware of any changes or updates to the policy.

_____ _____

Patient's Name Printed **Patient's Date of Birth**

_____ _____

Signature **Date of Signature**

_____

Legal Guardian's Name Printed (if applicable)