statcare
Urgent & Walk-In Medical Care

Patient Treatment Agreement

For Statcare Urgent & Walk-in Medical Care ("Statcare") & Hicksville Family Medical Care ("HFMC")

Signing a new agreement today at any Statcare/HFMC location supersedes patient agreements that Statcare/HFMC may have on file.

General Consent for Treatment: I wish to receive medical care from Statcare/HFMC. I hereby authorize the physicians, medical providers, allied healthcare workers, and professional staff at Statcare/HFMC to provide medical treatment to me or the patient named herein for whom I might be making this payment for. I agree with getting diagnostic tests and procedures, including X-rays, injections or administration of pharmaceutical products/medications, drawing of blood or getting internal exams done. I acknowledge that no guarantees or assurances have been made to me concerning the results or findings intended from treatment, examination or outcome of the proposed treatment plan at Statcare/HFMC. I release Statcare/HFMC from all liability due to the loss or damage of any valuables or personal belongings.

Notice of Privacy Practices and Patient's Bill of Rights: I have read the HIPAA form and Patient Bill of Rights.

Verification of Insurance Eligibility & Insurance Authorization: I understand that if my eligibility for coverage by my insurance company cannot be confirmed and it is determined that I am not eligible for coverage I will be responsible for payment of all services provided to obtain authorization for services rendered. I understand that I am responsible for notifying my insurance company to obtain authorization for services rendered. I understand that all accrued charges may not be reflected at the time of check out. I may receive a statement that will detail additional accrued charges, such as unsatisfied deductible balances, laboratory, radiological services, or special procedures. I understand that all charges will be filed with the insurance information on file if provided by me at the time of the visit. Statcare/HFMC will file a claim to the insurance carrier that I provide them with today. Statcare/HFMC does not guarantee payment

from my insurance carrier. It is my responsibility to know the details of my insurance policy and my covered benefits. After the insurance company has processed my claim, I will receive a bill for the amount due and I will be responsible for the billed amounts if any. I guarantee that when the claim is filed for my visit if my insurance is not active, I will be responsible for the full payment due. As per New York State law, Statcare/HFMC has informed me that any person who knowingly and with intent to defraud any insurance company, physician, or any other health care practitioner is committing fraud, which is a crime. NY Penal Code, Section 176.05- The failure to provide accurate information as to your insurance coverage, or the obtainment of services through deception by use of insurance IDs that constitute a fraudulent act. Such acts are subject to a civil penalty not to exceed $5000 and the stated value of the claim for each violation. It is the policy of Statcare/HFMC to report all insurance fraud to the New York State Commissioner of Insurance, Insurance Fraud Bureau. I understand that I am financially responsible for any accrued charges and that a late fee of $25.00 will be assessed for each invoice that I receive every 30 days. In addition, I agree to pay any charge-back fees. If the account is referred to collection, I agree to pay all collection fees, interest, court costs, and attorney fees. At the time of the visit, I agree to pay Statcare/HFMC the following: 1. Co-payments as set by my insurance carrier 2. An initial fee of $100 towards my deductible (if applicable) 3. Any other amounts that my insurance co deems to be my responsibility (costs of all vaccines for preventative care, or amounts not covered by my insurance carrier either based upon my insurance plan or because my insurance card is inactive or invalid. 4. Cost for the office visit as set by Statcare/HFMC if I do not have valid insurance and failed to declare it at the time of my visit. 5. I acknowledge that any and all X-rays are taken at this facility are part of the medical record and property of Statcare/HFMC. A report of the findings may be obtained upon request. A CD containing the X-Ray film may be purchased for $15. I have the right to receive an itemized statement by mailing a written request to Statcare/HFMC or by calling the office at (917) 310-3371.

Assignment of Benefits: I assign the benefits payable for the physician's services to Statcare/HFMC to submit a claim to Medicare/Medicaid for payment.

Responsibility for Credit Dispute: I understand that if I initiate a dispute with my credit card company in regards to a payment made to Statcare/HFMC, that I will be responsible for the

$50.00 cost (includes time, labor and chargeback fees) incurred as a result of the dispute investigation.

Responsibility for paying the copay or deductible: A $10.00 charge will be added to any patient who refuses to pay for their copay at the time of visit.

Telephone Policy, Prescription History, Patient Portal, Text, Voice Message, Web-Enabling For Patient Portal

I acknowledge, understand, and accept Statcare/HFMC HIPAA and patient privacy policy which exists to protect my privacy and that Statcare/HFMC staff will not be discussing my lab or imaging results over the phone, or with anyone else without my written consent.

I give Statcare/HFMC permission to access my external prescription history to enable quality medical care.

I agree to be web-enabled which will allow me to access my blood test results, keep track of appointments, update patient demographic information and access to patient education materials at Statcare/HFMC. I understand and acknowledge that receipt of or use of the text messaging service from a terminal such as a mobile device is subject to any agreements I have with my cellular network carrier and any fees that they may charge, including but not limited to fees for text messages, data usage or internet access. Any and all fees are my sole responsibility and not that of Statcare/HFMC.

I give permission for Statcare/HFMC to share Statcare/HFMC Business Contact information via text message to me on my cell phone. (Statcare/HFMC Business Contact information includes a contact number, contact email, business address, website, business hours and Statcare/HFMC services) I have fully read and understood this consent form and the policies and procedures regarding the Patient Portal.

If you have provided your insurance information during your visit today, our billing team will send a claim to your insurance company shortly after your visit. Once the claim is successfully processed, your insurance company will send us a statement with the amount you owe. If you have a remaining balance, you will receive a statement with the amount you owe as a text message and in the mail. For your convenience, we will charge the credit card you have left on file with us. There will be approximately 15 days from the time you receive the statement to the time your card is charged. If you would like to make other arrangements to pay off your balance or have questions regarding your statement, please contact us before the date on your

statcare
Urgent & Walk-In Medical Care

statement. Our billing team's email address and phone number will be listed on the statement. By signing this form you are consenting to leave a credit/debit/HSA or FSA card on file with Statcare/HFMC. Your information will be stored using the same encrypted, secure software used to store your medical records. You are also consenting to have your credit/debit/HSA or FSA card charged for any remaining balance you may owe. I have read and agreed to the Credit Authorization.

Medical Care:

The evaluation and treatment I am receiving today are being rendered on an urgent care basis only. Follow up care by my own doctor or at a follow-up visit at Statcare/HFMC for the specific problem identified recommended for re-examination and for any new or continuing problems that might be getting worse is difficult to diagnose and treat all aspects of an injury or illness in one visit at Statcare/HFMC.

All X-Rays done at Statcare/HFMC will be interpreted by a Radiologist to confirm the initial interpretation by the medical provider. If there is a change in the diagnosis, you and/or your doctor will be notified by one of the medical staff. Fractures or abnormalities may not show on X-Rays for several days. I understand that if my symptoms persist or get worse, then I must follow up with Statcare/HFMC or my own Primary Care Physician ASAP.

I understand that I need to follow all the instructions given to me today.

I understand if my symptoms worsen or continue, then I must return to the Statcare/HFMC or see my own Primary Care Physician immediately. I am aware that I can reach Statcare at (917) 310-3371.

Health Information Exchange
I give consent to all the Health Information Exchange participants listed on the HIE website and Care Everywhere Providers to access all of my electronic health information through the HIE and I give consent to all employees and agents of Statcare/HFMC to access all of my electronic health information through HEALTHIX in connection with any of the permitted purposes described in the fact in sheet, including providing me any health care services, including emergency care.

_____	_____	_____
Print Name	Signature	Date

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Urgent & Walk-In Medical Care

Patient Authorization For Practice To Release

Protected Health Information To Third Parties

For Statcare Urgent & Walk-in Medical Care ("Statcare") & Hicksville Family Medical Care ("HFMC")

By signing this authorization, I authorize Statcare/HFMC to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below. This authorization permits Statcare/HFMC to use or disclose to

(Person or entity to receive the information) the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, the origin of information, etc.).

This authorization will expire on **31-Dec-2021** (Expiration date or defined event).

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Statcare/HFMC has acted in reliance upon this authorization. My written revocation must be submitted to Statcare/HFMC.

_____	_____	_____
Print Name	Signature	Date

Financial Policy Agreement

For Statcare Urgent & Walk-in Medical Care (“Statcare”) & Hicksville Family Medical Care (“HFMC”)

Signing a new agreement today at any Statcare/HFMC location supersedes patient agreements that Statcare/HFMC may have on file.

As a courtesy, Statcare/HFMC, verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, if your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received.

It is the policy of Statcare/HFMC that payment is due at the time of service unless other financial arrangements are made in advance. We require all patients to pay their deductible, copay and/or coinsurance payment at the beginning of each visit. The office manager at your location will explain this information to you prior to your first visit. At the conclusion of your visits with us you may be billed for any outstanding balances. If there is a credit, you will be provided a refund promptly.

If you are covered by health insurance for visiting Statcare/HFMC offices, we will be happy to bill your insurance. Please provide your insurance information to the front office staff and we will verify your coverage as a courtesy. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan.

Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100 percent responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment.

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Urgent & Walk-In Medical Care

We highly recommend you also contact your insurance carrier and check into your coverage for visiting Statcare/HFMC offices. Do not assume that you will not owe anything if you have more than one insurance policy.

I understand and accept the instructions/information listed above in this document.

_____	_____	_____
Print Name	Signature	Date

Appointment Cancellation Charge

For Statcare Urgent & Walk-in Medical Care (“Statcare”) & Hicksville Family Medical Care (“HFMC”)

By signing this form, I understand and acknowledge that if I cancel any of my pre scheduled and confirmed appointments for any reason I will be assessed a $50 cancellation fee per appointment. Statcare/HFMC will be billing me for the cancellation fee and also I am responsible for any information that is incorrect and Statcare/HFMC should not be held liable for this information.

Also, if Statcare/HFMC is not paid within 60 days from my visit I would be responsible for the cost (includes time, labor, statement fees and charges)

_____	_____	_____
Print Name	Signature	Date

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Patient Authorization Billing and Verifying Patient Information With Practice

For Statcare Urgent & Walk-in Medical Care (“Statcare”) & Hicksville Family Medical Care (“HFMC”)

By signing this form, I understand that I have reviewed below listed items while checking in and verified that my information with Statcare/HFMC to make sure that Statcare/HFMC is paid for any and all charges related to my services and also I am responsible for any information that is incorrect and Statcare/HFMC should not be held liable for this information.

Also, if Statcare/HFMC is not paid within 60 days from my visit I would be responsible for the cost (includes time, labor, statement fees and charges). Please note that if your insurance is not attached, we will assume that you are self-pay and we will expect you to pay the full price.

1. Name
2. Mailing Address
3. Phone Number
4. Email Address
5. Insurance Information
6. Co-Pays
7. Pharmacy Information
8. Deductible - if any
9. Outstanding balance - if any
10. Credit Card Information
11. Emergency Contact Information
12. Guardian’s Information - if any

_____	_____	_____
Print Name	Signature	Date

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Consent For Telehealth Services

For Statcare Urgent & Walk-in Medical Care (“Statcare”) & Hicksville Family Medical Care (“HFMC”)

I understand that my health care provider wishes to engage in a telehealth visit or series of visits. I understand that these encounters will not be the same as a direct patient-provider visit because I will not be in the same room as my healthcare provider. Instead, we will be communicating using two-way simultaneous audio-visual technology ("the technology").

I understand that I have the right to refuse to participate in any telehealth encounter at any time or to end it at any point during the encounter. I understand that if I do not wish to participate in a telehealth encounter, I will need to either make an appointment for an in-person visit with my provider or seek care at the closest emergency department if I believe that my symptoms warrant that level of care. I further understand that my provider may not be able to accommodate an in-person visit and there may be a delay in my care if I choose an in-person visit.

I understand that my healthcare provider can discontinue the telehealth encounter if he or she believes that this technology does not meet the standard of care necessary to address my medical concerns. If that happens, I understand that I will need to either make an appointment for an in-person visit with my provider or seek care at the closest emergency department if I believe that my symptoms warrant that level of care.

I understand how the technology will be used to conduct any telehealth encounters with this practice. I also understand that, with this technology, there is a risk of interruption and technical difficulties.

I have had the opportunity to ask questions about telehealth encounters and the technology. My questions have been answered and the risks, benefits, and any practical alternatives have been discussed with me in a language that I understand.

I understand that I will be told the identity of everybody who will be in the room with my healthcare provider during any telehealth encounter and that those people will be present only because my healthcare provider has determined that their presence is necessary to assist in my medical treatment according to the applicable standard of medical care.

I have been told whether my provider is licensed to provide medical care in the state where I am located. If they are not licensed in the state where I am located, I consent to receive telehealth services anyway because the provider is fully licensed in the state where they are located.

I understand that I will be responsible for any copays and coinsurance that apply to my telehealth encounter(s). This consent will remain valid for six (6) months from the date of my first telehealth visit with the practice listed at the top of this consent.

_____	_____	_____
Print Name	Signature	Date

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Urgent & Walk-In Medical Care

Credit Card Authorization

For Statcare Urgent & Walk-in Medical Care (“Statcare”) & Hicksville Family Medical Care (“HFMC”)

If you have provided your insurance information during your visit today, our billing team will send a claim to your insurance company shortly after your visit. Once the claim is successfully processed, your insurance company will send us a statement with the amount you owe. If you have a remaining balance, you will receive a statement via text message with the amount you owe. For your convenience, we will charge the credit card you have left on file with us. There will be approximately seven days from the time you receive the statement to the time your card is charged.

If you would like to make other arrangements to pay off your balance or have questions regarding your statement, please contact us before the charge date on your statement. Our billing team’s phone number will be listed on the statement.

By signing this form you are consenting to leave a credit/debit/HSA or FSA card on file with Statcare Urgent & Walk-In Medical Care or Hicksville Family Medical Care. Your information will be stored using the same encrypted, secure software used to store your medical records. You are also consenting to have your credit/debit/HSA or FSA card charged for any remaining balance you may owe.

Credit Card Number: _____

Date of Expiration (mm/yy): _____

CVV: _____

Name on Card: _____

Billing Zip Code: _____

_____	_____	_____
Print Name	Signature	Date

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Insurance Information

Please attach photos of your insurance card(s). Make sure that these photos are clear and ensure that the information is readable. If you do not have ANY health insurance coverage (recorded in New York State database) AND are a resident of New York State only then upload your New York State Drivers License or Photo ID in lieu of your insurance card(s).

Primary

Front

Back

Secondary

Front

Back

Please attach the front and back of your Drivers License or Photo ID here:

Front

Back

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Urgent & Walk-In Medical Care

Offices in NYC, Brooklyn, Queens, Bronx & Long Island
Open Sat. Sun.& Holidays

Phone: (917) 310-3371
Email Documents to: frontdesk@statcarewalkin.com
Website: www.statcarewalkin.com

Informed Consent & Authorization

For

COVID19 (IgG) Antibody Test At

Statcare Urgent & Walk-in Medical Care ("Statcare") & Hicksville Family Medical Care ("HFMC")

Statcare/HFMC is offering COVID19 Antibody (IgG) Tests. This COVID19 Antibody (IgG) Test is offered under Emergency Use Authorization (EUA) by the FDA. (https//www.fds.gov/media/135659/download). Please visit www.fda.gov for information about COVID (IgG) Antibody tests and FDA guidance on them.

These COVID19 Antibody (IgG) Tests perhaps might be covered either by your insurance or by the federal or NY State governments. However, Statcare/HFMC cannot guarantee that these tests will be covered by any health plan or government agency. You can choose to pay $75 for a full payment towards this test to avoid any billing issues later. Our recommendation is that you wait for the Explanation of Benefit from your insurer, once they adjudicate the claim by the Lab.

By signing this form, you are consenting that: "I expressly, willing, and voluntarily assume full responsibility for all risks of any and every kind involved with or arising from my participation in getting this COVID19 Antibody Testing done. I hereby irrevocably release, waive, discharge, hold harmless, defend, and indemnify Statcare/HFMC, its employees, agents, representatives, contractors, subcontractors, successors, heirs, assigns, affiliates, and legal representatives (the "Released Parties") from any and all claims, actions, or losses for bodily injury, property damage, wrongful death, loss of services or otherwise, and hold them harmless for, all claims, rights, demands or causes of action whether known or unknown, suspected or unsuspected, arising out of this or relating to this COVID19 Antibody Testing or the Covid19 Antibody Test results or the actions I undertake based on those test results".

_____	_____	_____
Print Name	Signature	Date

Race:
Ethnicity:
Language:

For COVID Testing Contact Tracing The Following Is Required:

Employer/School District Name:
Employer/School District Address:
Employer/School District State:
Employer/School District Zip:
Employer/School District Phone Number:
Job Title/Student:
Have you been at work/school in the last 7 days:

DEMOGRAPHIC DETAILS

PERSONAL DETAILS

*First Name _____

Middle Initial _____

*Last Name _____

*Email _____

*Date Of Birth _____

*Sex _____

*Address 1 _____

Address 2 _____

*City _____

*State _____

*Zip _____

*Home Phone _____

*Cell Phone _____

EMERGENCY CONTACT

*Last Name _____

*First Name _____

*Relation _____

*Phone _____