Ventura Urgent Care
a member of the visit health network.
5725 Ralston Street, Suite 101, Ventura, CA 93003 (in Victoria Village)
(805) 658-2273 | venturaurgentcare.com | inquiries@visithealth.com

Member Acknowledgment of Financial Responsibility

Member

Your signature on this form acknowledges that you agree to bear full financial responsibility for all services provided as listed below if:

or

1. The services are not covered under your medical insurance plan.
2. The services have not been otherwise approved for payment by your medical plan.

Services

Any service not described as a covered benefit in the member's Evidence of Coverage.

_____

_____

Patient's Name (please print): _____ Account #: _____

Patient's Signature: _____ Date: _____

Ventura Urgent Center Representative's Signature: _____ Date: _____

Acknowledgment of Receipt of Privacy Notice

I have been presented with a copy of Ventura Urgent Care's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice. I permit a copy of this authorization to be used in place of the original, and request payment of medical benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signature: _____ Date: _____

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

Relationship: _____ Witnessed by: _____

Acknowledgment to Release Medical Records

I authorize Ventura Urgent Care to release my:

- ☐ Name, address, phone, SSI#
- ☐ Diagnosis/ Health status
- ☐ X-rays / Diagnostic tests / Results
- ☐ Insurance policy information
- ☐ Laboratory tests / Results
- ☐ Immunization records
- ☐ Physical examination results
- ☐ Employer information
- ☐ Confidential information (HIV, STD, substance abuse, mental health info/results)

To (name the person or entity): _____ By means of: ☐ Email ☐ Mail ☐ Phone ☐ Other _____

For the purpose of: _____

This authorization is effective on the date signed and continues until:

I give permission to Ventura Urgent Care to release my PHI, and if I refuse to authorize the release of my health information, Ventura Urgent Care may refuse to treat me.

_____ _____

Date Patient's Signature