CONSENT INFORMATION

CONSENT TO TREAT

I (or my child/ward) need diagnostic, medical or surgical treatment and voluntarily consent to such procedures and care and to such medical, surgical or other services under the general and specific instructions of Yubadocs Urgent Care, their assistants, and or designees as is necessary in their judgment. I also acknowledge that the practice of medicine is not an exact science and that Yubadocs has made no guarantees to me as to the result of treatments or examination.

CONSENT FOR LEAVING MESSAGES

I give consent for Yubadocs to leave phone messages.

E-MAIL CONSENT

By providing my email address, I give Yubadocs Urgent Care permission to email me directly or through a third party to survey me regarding my visits for the purpose of patient satisfaction and quality assessment.
Yubadocs will not share my email address or medical records with others.

MEDICATION HISTORY CONSENT

In order to electronically prescribe medications and to help assure continuity of care, I consent to have my medication history downloaded through Surescripts.

LABORATORY DISCLAIMER

If the clinician orders laboratory tests that are sent to an outside lab, I understand I will receive a separate bill from that lab. I understand that Yubadocs collects laboratory specimens as a service to patients, and has no financial interest in any lab or in any tests sent to an outside lab. I understand my billing information will be sent to the lab along with my laboratory specimen(s). I understand the laboratory will bill participating insurance companies, but any unpaid portion of my lab bill is my responsibility.

PAIN MANAGEMENT

Yubadocs providers are able to assist our patients with all types of acute (recent/short term) pain resulting from injury or illness. Chronic pain (that which lasts or has been present intermittently for a period longer than three months) is best treated by certified Pain Management Specialist.

My signature confirms I understand and agree to all of the above.

Patient Name_____

Signature X_____ Date: _____
Patient/Parent/Custodian/Guarantor