Authorization and Agreement for Medical Treatment

The undersigned hereby makes the following acknowledgements and agreements regarding medical treatment to be provided to the patient whose name appears on this page.

Consent for Treatment: I understand that medical treatment of an urgent nature is necessary for the patient and that such medical care, treatment, and procedures will be performed by independent physicians, their physician assistants, and by employees at VIK Medical between the posted hours of each clinic. And that no responsibility will be taken during non operating hours. (If you do not have a private physician, Brackenridge, Seton, St. David's and South Austin Hospitals provide 24-hour emergency care). I hereby grant my authorization and consent to such treatment and procedures, and certify that no guarantee or assurance has been made as to the results which may be obtained.

Selection of Personal Physician: I understand that if hospitalization or other treatment is required, VIK Medical will attempt to contact the patient's personal physician to provide this service. If the patient does not have a personal physician or the personal physician cannot be contacted, VIK Medical physician may select another physician to service care.

Agreement to Pay at Time of Service: For an in consideration of the care and treatment provided to this patient, I promise to pay VIK Medical all charges for services rendered to or on behalf of the patient. I understand that I may be responsible for the charges for services if my employer does not subscribe to workers' compensation insurance and fails to pay.
Estimation of charges – I understand that any prices quoted to me prior to treatment are only an estimate. Exact costs can only be determined after assessment by the physician.

Release of Medical Information: I hereby authorize VIK Medical to release any medical information obtained from these services to: 1) health insurance provider as may be required for reimbursement, 2) my personal physician, or 3) to specialist physician if referral is required.
Work Related Injury of Illness – I hereby authorize VIK Medical to release my employer's insurance representative, as may be required for reimbursement, any information obtained in evaluation, treatment, diagnosis, and disposition of any work related injury or illness. I understand this may include personal medical information (e.g. lab results, medications, etc.) concerning HIV status and/or mental health status.

Employment Physical Exams: I hereby authorize VIK Medical to release to my employer or prospective employer any information obtained by VIK Medical in connection to job suitability or pre-placement evaluations required by my employer regarding employability, including limited physical exam, spirometric, audiometric, radiographic exam, functional capacity exams and result of any blood, urine, and hair specimens collected, in connection with such job placement evaluations.

Assignment of Benefits: (Applicable only to insurance plans in which VIK Medical is a contracted provider). I authorize payment of medical benefits to VIK Medical.

VIK Medical does NOT accept Medicaid insurance reimbursement.

Patient's Name: ________________________________ Date of Birth: __________________

Legal Guardian's Name: _________________________ Relationship to Patient: _________

Signature of patient **OR** legal guardian: ___________________________ Date: ____________