URGENT CARE PATIENT INTAKE & CONSENT PACKET

Urgent Care — Professional Corporation

B2-01 | Version 2.0 Updated | Effective Date: [Date]

1. General Consent to Evaluation and Treatment

(SIGNATURE REQUIRED)

I voluntarily consent to evaluation and treatment at this urgent care center by licensed healthcare professionals acting within their scope of practice.

I understand that urgent care services are provided to address acute medical concerns. Clinical decisions are based on professional judgment, patient presentation, and information reasonably available at the time of the encounter.

I authorize the treating clinician to perform medically appropriate examinations, diagnostic testing, procedures, and treatments reasonably necessary to evaluate and manage my condition.

Evaluation is limited to the urgent care scope and available outpatient resources at the time of the encounter.

I understand that:

- No specific outcome or result is guaranteed.
- I may ask questions about my care at any time.
- I may decline or withdraw consent for treatment at any time.
- In the event I am unable to provide consent during an urgent or emergent condition within the capabilities of this facility, treatment may be provided as permitted by law under the principle of implied consent.

If signing on behalf of a minor or dependent adult, I represent that I am the legal parent, guardian, or authorized representative with authority to consent to treatment.

Patient Name: _____

Signature: _____

Relationship to Patient (if applicable): _____

Date: _____

2. Financial Responsibility, Assignment of Benefits & Insurance Disclosure

(SIGNATURE REQUIRED)

Insurance verification is performed as an administrative courtesy and does not guarantee coverage or payment. Final determination of benefits is made by my insurance carrier after claim submission.

I agree to be financially responsible for charges to the extent permitted by applicable law and my health plan terms, including applicable copayments, deductibles, coinsurance, and non-covered services. If my insurance plan is out-of-network, I understand I may be responsible for a greater portion of the charges consistent with applicable law.

Amounts collected at the time of service are estimates based on information reasonably available at that time. Additional billing or refunds may occur following insurance adjudication. Financial policies are

available upon request.

Assignment of Benefits: I authorize payment of insurance benefits directly to the Professional Corporation for services rendered. This authorization remains valid for the current episode of care unless revoked in writing to the extent permitted by applicable law and payer requirements.

Authorization for Release for Payment & Operations: I authorize the release of medical information reasonably necessary to process claims, obtain payment, and conduct healthcare operations as permitted by applicable state and federal law.

Patient Name: _____

Signature: _____

Date: _____

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3. Clinical Photography Authorization

(SIGNATURE REQUIRED)

I authorize the taking of clinical photographs or digital images when medically appropriate for documentation of my condition, procedures, or treatment.

I understand that such images:

- Become part of my confidential medical record.
- Are used for clinical care, documentation, healthcare operations, and related purposes permitted by law.
- Are protected in accordance with applicable privacy laws.

Clinical images will not be used for marketing, advertising, or public display without separate written authorization.

Patient Name: _____

Signature: _____

Date: _____

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4. Notice of Privacy Practices (HIPAA Acknowledgment)

(ACKNOWLEDGMENT REQUIRED)

I acknowledge that I have been informed of the availability of the Notice of Privacy Practices describing how my health information may be used and disclosed in accordance with federal and California law.

I understand that I may request a copy of the Notice at any time.

Patient Initials: _____ Date: _____

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5. Patient Rights & Responsibilities

(ACKNOWLEDGMENT REQUIRED | POSTED IN CLINIC)

I acknowledge that I have been informed of my rights and responsibilities as a patient, including:

- The right to respectful, non-discriminatory care
- The right to participate in medical decision-making
- The right to privacy and confidentiality of my health information
- The right to receive information about my diagnosis, treatment, and prognosis in terms I can understand
- The right to decline recommended treatment after being informed of the potential consequences
- The ability to raise concerns or complaints without retaliation or impact on access to care

Patient Initials: Date:

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6. Language Assistance & Accessibility Notice

(ACKNOWLEDGMENT REQUIRED | POSTED)

Language assistance services, including interpreter services, are available at no cost when needed. I may request assistance at any time.

Reasonable accommodations are available for individuals with disabilities in accordance with applicable law.

Patient Initials: Date:

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7. Consent to Contact & Communication Preferences

(SIGNATURE REQUIRED)

I authorize the practice to contact me regarding my care, including communication of diagnostic results, follow-up recommendations, and appointment information, using the contact methods I have provided.

Preferred contact method (check all that apply):

- ■ Phone call
- ■ Text message (SMS)
- ■ Secure patient portal
- ■ Email

I understand that electronic communications may carry inherent privacy limitations. Standard text messaging and email are not encrypted unless otherwise specified. The practice will use reasonable safeguards consistent with applicable privacy laws. I may update my contact preferences at any time by notifying the front desk. The practice may use reasonable discretion in selecting communication methods based on clinical urgency and operational considerations.

Patient Name: _____

Signature: _____

Date: _____

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8. Telehealth Consent

(SIGNATURE REQUIRED WHEN TELEHEALTH IS USED)

California B&P; §2290.5 Disclosure This section satisfies the telehealth informed consent requirements of California Business & Professions Code §2290.5(b). It applies whenever a provider joins your visit by audio-video rather than in person.

I consent to receive care via telehealth, which uses electronic audio-video communication technology to deliver medical evaluation and treatment when my provider is not physically present at the clinic.

I understand and acknowledge the following:

- My consent to telehealth is voluntary. I may withhold or withdraw consent at any time before or during the encounter without affecting my right to receive future care from this practice.
- I have the right to request in-person care as an alternative to telehealth. If I prefer an in-person visit, the practice will make reasonable efforts to accommodate that request based on scheduling availability and operational capacity.
- I may request a different provider if I decline to proceed with the telehealth encounter as offered.
- Telehealth has inherent limitations, including the absence of hands-on physical examination by the remote provider, dependence on technology availability and connection quality, and the possibility of technical failure that may require rescheduling or conversion to an in-person visit.
- Electronic transmission of my health information carries privacy risks. The practice uses HIPAA-compliant platforms and safeguards to protect my information. In the event of a breach of confidentiality, I have rights as described in the Notice of Privacy Practices (Section 4).
- The provider may determine at any point that in-person evaluation is clinically necessary, and I will be informed and offered appropriate next steps.
- Telehealth services are held to the same standard of care as in-person visits.
- Telehealth encounters are not recorded without my separate explicit authorization. California law (Penal Code §632) requires all-party consent to recording.

By signing below I confirm that these disclosures have been communicated to me and that I consent to receive care via telehealth on the terms described above.

Patient Name: _____

Signature: _____

Relationship to Patient (if applicable): _____

Date: _____

Staff attestation: Telehealth consent disclosures were communicated verbally and this section was completed. Documented in the clinical record.

Staff Name (Print): _____ Date: _____

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9. Acknowledgment of Urgent Care Scope

(ACKNOWLEDGMENT REQUIRED)

I understand that this facility is an urgent care center and is not a hospital or hospital emergency department.

The urgent care does not provide continuous monitoring, inpatient admission, or advanced critical care services.

The urgent care provides outpatient evaluation and limited management of acute conditions.

If my condition requires higher-level care, I may be referred or transferred to an emergency department or other facility as clinically indicated.

Patient Initials: Date:

END OF PATIENT INTAKE & CONSENT PACKET

B2-01 v2.0 Updated | La Esperanza Health Optimization | Cross-references: B1-14 §6, B2-TH