Below is a formal **Uninsured Services Work Request and Patient Financial Consent Agreement** that can be used by 595 Wonderland Road North Medical Clinic. It establishes the patient's responsibility for payment, including urgent-service surcharges and any balance not covered by the requesting institution.
Writing

595 Wonderland Road North Medical Clinic
Uninsured Services Work Request & Patient Financial Consent Agreement

Patient Information

- Patient Name: _____
- Date of Birth: _____
- Health Card Number (if applicable): _____
- Contact Number: _____
- Date of Request: _____

Requesting Institution / Organization

- Institution Name: _____
- Department / Representative: _____
- Contact Information: _____

1. Authorization for Uninsured Services

I hereby authorize 595 Wonderland Road North Medical Clinic to provide the requested medical, administrative, clinical, or other uninsured services on my behalf, at the request of the institution or organization identified above.
I understand that the requested services may not be covered by OHIP, private insurance, or the requesting institution.

2. Consent to Pay for Services

I voluntarily agree to assume financial responsibility for all fees associated with the requested uninsured services.
I acknowledge and agree that:

- I am responsible for the full cost of the requested services.
- If the requesting institution agrees to cover only part of the cost, I agree to pay the remaining balance.
- If the institution refuses payment, delays payment, or does not cover the entire amount, I remain responsible for the outstanding balance.
- Payment is due in accordance with the clinic's payment policies.

3. Urgent and Expedited Service Fees

I understand that requests requiring urgent, expedited, or priority processing may be subject to an additional **30% surcharge** over the regular service fee.
This surcharge applies regardless of which institution, employer, organization, or third party initiates or requests the service.

By signing this agreement, I acknowledge and consent to the additional 30% fee when urgent processing is requested or required.

4. Financial Responsibility Regardless of Institutional Coverage

I understand that the requesting institution's involvement does not automatically guarantee payment or reimbursement.

I expressly agree that I will pay any difference between the total clinic fee and the amount paid or reimbursed by the requesting institution or any third party.

My financial responsibility remains in effect regardless of the institution's payment arrangements, reimbursement policies, or eligibility requirements.

5. Patient Acknowledgment and Consent

I confirm that:

- I have been informed that the requested services may be uninsured.
- I understand the applicable service fees and potential urgent-service surcharge.
- I have had the opportunity to ask questions about the fees.
- I voluntarily consent to the requested services and accept the associated financial responsibility.
- I understand that this agreement does not guarantee that the institution will reimburse me.

6. Signatures

Patient / Authorized Representative

Name: _____

Signature: _____

Date: _____

Relationship to Patient (if applicable): _____

Requesting Institution Representative (if applicable)

Name: _____

Position: _____

Institution: _____

Signature: _____

Date: _____

For Clinic Use Only

- Service Requested: _____
- Regular Service Fee: $_____
- Urgent Surcharge (30%, if applicable): $_____
- Total Amount: $_____
- Institution Contribution: $_____
- Patient Responsibility: $_____

Authorized Clinic Staff: _____

Date: _____

595 Wonderland Road North Medical Clinic

Patient Financial Consent — Uninsured and Institution-Requested Services