

Description of Injury/Symptoms _____ Insurance Self Pay Work Related

PATIENT INFORMATION

Name (Last, First, Middle) _____ Social Security # _____
 Sex M F Age _____ Birth Date _____ Single Married Widowed Separated Divorced
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Mobile/Work Phone _____ Preferred Home Mobile/Work
 Email _____ How did you hear about us? _____
 Patient Employed By _____ Supervisor _____
 Primary Care Physician _____ Phone _____
 In case of Emergency (Name, Phone, Relation) _____

PARENT/GUARANTOR INFORMATION

Name (Last, First, Middle) _____
 Social Security # _____ Age _____ Birth Date _____ Sex M F
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Mobile/Work Phone _____ Preferred Home Mobile/Work
 Email _____ Relationship to Patient Parent Guardian Spouse Employer

PRIMARY INSURANCE

Carrier _____	Policy Holder Name _____
Subscriber ID _____ Group # _____	Social Security # _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F
Insurance Claims Address _____	Birth Date _____
Phone _____	Relationship to Patient <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Spouse

SECONDARY INSURANCE

Carrier _____	Policy Holder Name _____
Subscriber ID _____ Group # _____	Social Security # _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F
Insurance Claims Address _____	Birth Date _____
Phone _____	Relationship to Patient <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Spouse

AUTHORIZATION AND RELEASE

Authorization of Treatment: I voluntary consent to the administration and cost of medical and surgical procedures, x-ray and medication for myself and my dependents
Assignment of Insurance Benefits: I authorized payment directly to this urgent care center for all benefits otherwise payable to me.
Guarantee of Payment: I understand that I am financially responsible and agree to pay all of the charges that are not paid or billed to insurance or any other third party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance copays, coinsurances and deductibles today. If you are unable to verify my insurance at time of service, I will pay in full for all services.
Release of Records: I authorize this urgent care center to release (verbal or in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or other health care operation which may be liable to me or my practitioner(s) for charges for this treatment and for quality management, utilization review, transfer and follow-up purposes.
Receipt of Privacy Practices: I acknowledge that a copy of the Notice of Privacy Practices is available to me upon request.

I understand that a copy of this agreement may be used with the same effectiveness as the original.

Patient Signature _____ Date _____
 Responsible Party _____ Date _____