Urgent Care Center

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Martinsville, Virginia 24112
Phone: (276)638-2273
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Part 1 - Notice of Privacy Practice

Our practice is dedicated to maintaining the privacy of your individual identifiable health information (PHI). We are required by law to make this available to you. Our practice will post a copy of our current notice in our office in a visible location at all times. It is also available on our website and you my request a copy of our most current notice at all times.

Please sign below indicating that you have read and understand your rights to receive a copy of this notice. Below please list the names of the person/person's to whom we may disclose the patient's (PHI) Patient Health Information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Patient/ Parent/Legal Guardian Signature: **Patients Name (Printed):**

_____

Date:

Part 2 – Parental Consent to Treat Minor

If the patient is under the age of 18 years old and you would like to give permission for someone else to bring you minor child in to be treated, please complete the following. If the person is not listed on this form, they will not be allowed to bring the child in for treatment unless they have a written and signed letter from the parent or legal guardian.

I, _____ give my permission for the following person/people to bring my minor child in to Dr. Jon's Urgent Care Center to be treated for any medical issues.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

The following people will have knowledge of medication that the child is taking, as well as knowledge of any surgeries the child has had, any medical illnesses the child has and allergies that the child has to any medications. If any of our medical staff needs to reach a parent or legal guardian, they may call the following phone numbers, _____, _____. It is very important that you be reachable during this time by phone in case the Provider needs to speak with you.

_____ _____

Patient/ Parent/Legal Guardian Signature: **Patients Name (Printed):**

_____

Date: