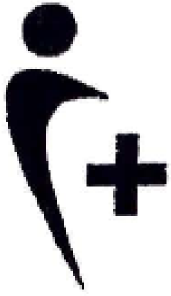

Family Urgent Care

Patient Demographic and Insurance Intake

Patient Name:________________________ Address:______________________

Date of Birth:______/_______/______ City:_______State:____Zip:______

SSN:______-______-_________ Home Phone: (_____)_____-_____

Gender (*please circle one*): M F Cell Phone: (_____) _____-_____

Marital Status (*please circle one*): E-mail:_______________________

M S D W Emergency Contact:____________

Parent/Guardian Name: Relationship:___________________

____________________________________ Phone: (_____) ______-______

Pharmacy Preference & Address:____

Insurance Information

Primary Insurance:____________________ Secondary Insurance:_______________

Policy Holder Name:________________	Policy Holder Name:______________
DOB:___/___/___SSN:_____-___-______	DOB:___/__/___SSN:_____-___-____
Address:___________________________ City:____________State:____Zip:______	Address:________________________ City:___________State:____ Zip:____
Phone Number: (_____) ______-_______	Phone Number: (_____) ______-______
Relationship:________________________	Relationship:_____________________

I am the (*please circle one*): patient | patient guardian

By signing below, I understand that I am responsible for services that are considered non-covered expenses by my insurer.

Signature:____Date:________________

Family Urgent Care

Patient Consent and Authorization

Patient Name:____________________________ Date of Birth:_____/_____/_____

HIPPA

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (**HIPPA**), I have certain rights to privacy regarding my Protected Health Information, I understand that the information can and will be use to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payors.
- Conduct normal healthcare operations such as quality assessment and physician certifications.

I understand that I may request in writing that you restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are required to agree to my requested restrictions, and if agreed, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I am the (*please circle one*):

patient | patient's guardian

Signature:________________________

Date:____________________________

Consent for Evaluation and/or treatment

By signing below, I ma giving my consent to the practice of Family Urgent Care for evaluation and/or treatment. Once I have been examined, I understand that I will be informed of any medically recommended diagnostic procedures and/ or treatments and given the option to accept or decline. **The consent will remain fully effective until it is revoked in writing. You can have the right at any time to discontinue services.**

I am the (*please circle the one*):

patient patient's guardian

Signature:________________________

Date:____________________________

Contact Information

Please list the person(s) with whom we can discuss your health information.

____

____

____