

PATIENT INFORMATION

Date: _____ May we leave lab results on answering machine? Y ___ N ___
Patient Name: _____ Birth Date: _____ M ___ F ___
Patient Age: _____ Date of Accident: _____ Names of family members also seen here _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Work Phone: (____) _____
Cell Phone: (____) _____ Preferred Contact: Home ___ Work ___ Cell ___
Social Security Number: _____ Marital Status: _____ Spouse: _____
Primary Care Physician: _____ Phone: _____ Date of Last Visit: _____
Emergency Contact: _____ Phone: (____) _____ Relationship _____
Which Doctor May We Release Medical Information To (Check One)? All PCP None
How did you hear about us? (Check One) Doctor Google Search Phonebook Internet Family/Friends Other _____

I DO NOT CARRY INSURANCE

I do not carry insurance and acknowledge that the charges will not be filed with any insurance companies. I will be responsible for all charges incurred at the time of service. INT _____

INSURANCE INFORMATION

Subscriber is the person who holds the policy - please fill out this section with **their** information

Subscriber Name: _____ Date of Birth: _____
Insurance Company: _____ Employer: _____
Co-Pay Required: _____ Employer's Phone Number: (____) _____
I.D. Number: _____ Group Number: _____

Assignment and Release:

- * I am aware that my account and referrals are ultimately my responsibility. This office cannot guarantee payment, coverage or benefits from my Insurance Company.
- * I authorize my Insurance benefits to be paid directly to URGENT CARE OF CO PC
- * I authorize the facility to release medical information to my PCP and/or for medical treatment, payment or daily operations.
- * I voluntarily consent to examination and treatment for myself and/or dependent.
- * If we can NOT fax personal health information upon request, please initial here: _____
- * **I accept responsibility for treatment costs incurred that are not covered by my Insurance Company.**
- * **All unpaid personal balances over 30 days will be charged a \$5.00 minimum fee and/or 1.5% interest per month.**
- * If my account defaults, I will be responsible for collections fees not to exceed 50% and reasonable attorney fees if required.

I have read all the above information, have been provided the opportunity to receive and acknowledge the Privacy Practices (HIPPA) and asked any necessary questions. I understand my obligations as outlined by this release. I understand that this release is valid for one (1) year from the date signed.

Patient Signature: _____ **Date:** _____

Parent Signature: _____ **Relationship:** _____ **Date:** _____