PATIENT
Urgent Care Clinic

PATIENT INFORMATION

Date: _____ Reason for Visit: _____

First Name: _____ MI: _____ Last Name: _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: _____ Race: _____ Social Security #: _____

Email address: _____ *By providing your email address, you consent to our Email Privacy Policy.*

Home phone: _____ Cell Phone: _____Work Phone: _____

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Employer Work Number: _____

Emergency Contact: _____ Phone: _____ Relationship _____

Patient Physician: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

Relationship to Responsible Party: Self ◯ Spouse ◯ Dependent ◯ Other ◯ _____

Responsible Party Name (if different from patient): _____

If Responsible Party's address is different than above, please fill in address:

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

How did you hear about Patient Plus Urgent Care?

◯ Building Signage ◯ Family/Friend/Referral ◯ Internet/Online Search ◯ Print Advertising ◯ Radio ◯ Event

Other: _____

CONSENT FOR TREATMENT + FINANCIAL OBLIGATION + USE OF PROTECTED HEALTH INFORMATION

I hereby consent to medical evaluations, testing, and/or treatment provided by the staff of this medical facility. I authorize information and subsequent visits to be relayed verbally, written, or faxed to my family doctor, commercial insurance company, and/or employer, if applicable.

I understand that even though I may have an insurance claim pending, I ultimately remain responsible for the account balance. Patient Plus does not accept responsibility for collecting an insurance claim or for negotiating a disputed claim. In the event of non-payment, I will be responsible for any collection and legal fees associated with the balance due. If I decline to swipe my card this visit, I understand it is my responsibility for following visits to notify the Patient Plus employee who is about to swipe my card if I still wish to decline.

I acknowledge that upon request I can receive the Notice of Privacy Practices and the Notice of Nondiscrimination of Patient Rights and Responsibilities. I have read this policy and agree to the terms within for services rendered.

Signature: _____ Date: _____