

 **URGENT CARE**

PLEASE PRINT

PATIENT 1ST NAME _____ MI _____ LASTNAME _____

SS# _____ DOB _____ GENDER ___ M ___ F MARITAL STATUS _____

EMPLOYER _____ HOW DID YOU HEAR ABOUT US? _____

PATIENT ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ CELL PHONE _____

EMERGENCY CONTACT (OTHER THAN SPOUSE) _____

RELATIONSHIP _____ PHONE _____

SPOUSE NAME _____ DOB _____ SS# _____

PARENT INFORMATION (IF PATIENT IS UNDER 18)

FATHER _____ DOB _____ SS# _____

ADDRESS _____ PHONE _____

EMPLOYER _____ EMPLOYER PHONE _____

MOTHER _____ DOB _____ SS# _____

ADDRESS _____ PHONE _____

EMPLOYER _____ EMPLOYER PHONE _____

It is the policy of this office, the parent accompanying the child for treatment will be responsible for all outstanding balances. However in the event the account is turned to our collections agency both parents will be pursued for payment. This office did not enter into therefore, is not responsible for any divorce decrees mandating which parent is responsible for medical bills.

I hereby authorize my insurance benefits to be paid directly to Springs Urgent Care, realizing I am responsible to pay all deductibles, co-pays, and co-insurance amounts. I hereby authorize the release of pertinent medical information to insurance carriers. I understand that if any unpaid balance is assigned to a third party collection agency for collection of places an attorney to obtain judgment or otherwise satisfy payment of my account, a collection fee of 33 1/3% will be applied to my account. I agree to pay that fee. I also agree to pay reasonable attorney fees and court costs. My signature indicates I understand and agree to the terms above.

Signature of Responsible Party _____ Date _____



SPRINGS URGENT CARE
PRIVACY CONSENT FORM
FOR THE PURPOSE OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

By signing this form I consent to allow Springs Urgent Care to use or disclose my Protected Health Information (PHI) for the purpose of (TPO) which includes

- Providing Treatment to me,
- Obtaining Payment for healthcare services provided to me,
- To carry out the practice's health care Operations,
- TPO conducted by another provider/entity including data for quality assessments and reviewing competence of health care providers.

If you would like anyone to be able to receive or discuss your Protected Health Information (PHI), including general information and/or billing information please list them here:

If my PHI includes any of the following chemical dependency/substance abuse, drugs, alcohol, sexually transmitted disease I agree to authorize release for those as well for TPO. If you do not ever want any of these disclosed please list them here:

Unless you expressly object or you are unable to agree or object, we may determine it is in your best interests based on our professional judgment to disclose such PHI information as necessary.

I also acknowledge that Springs Urgent Care has provided me with a copy of its Notice of Privacy, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding PHI. I may revoke my consent in writing except for prior disclosures. If I do not sign this consent, or later revoke it Springs Urgent Care may decline to provide treatment.

Signature of Patient or Representative

Date

Printed Name of Patient or Representative