Family Urgent Care

Consent to Treat
Demographics

PATIENT:	
DOB:	
ACCT #:	

Reason for Todays Visit : _____

Patient Information

First, Middle, Last Name: _____

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

Primary Phone: (___) _____ Secondary Phone: (____) _____

Date of Birth: _____ Gender: Male Female Marital Status: Single Married

Ethnicity: Hispanic Non-Hispanic Race: _____ Preferred Language: _____

Social Security #: _____ Employer: _____ Employer Phone: (____) _____

Primary Insurance

Insurance Company Name: _____ ID#: _____ Group#: _____

Policyholder's Name: _____ Patient's Relationship to Policyholder: ☐ Self ☐ Spouse Other: _____

Policyholder's Date of Birth: _____ Social Security #: _____ Phone: (____) _____

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

Secondary Insurance

Insurance Company Name: _____ ID#: _____ Group#: _____

Policyholder's Name: _____ Patient's Relationship to Policyholder: ☐ Self ☐ Spouse Other: _____

Policyholder's Date of Birth: _____ Social Security #: _____ Phone: (___) _____

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

Primary Care Doctor _____ Phone Number (___) _____
Pharmacy _____ Location _____ Phone Number (___) _____

Release of Protected Health Information: Please complete if you would like us to be able to discuss visit & follow-up questions with anyone other than yourself:

☐ **Checking this box authorizes release of your medical information to your spouse.**

Spouse's Name _____ Date of Birth _____ Phone# (___) _____

☐ **No other people authorized to receive my information. OR**

☐ **The following person is authorized.**

Name _____ Date of Birth _____ Phone Number (___) _____

Consent for Treatment: I hereby give my consent to receive treatment and authorization to release payment and information. I request the payment of authorized insurance benefits be made either to me or on my behalf to Family Urgent Care for any service furnished by this provider. I authorize any holder of medical information about me to be released to my insurance carrier and its agents and any information needed to determine the benefits payable for related service. I understand that as a service to me Family Urgent Care will bill all insurance. I understand I am responsible for payment of the balance. If balance is over 90 days past date of service, an interest fee may be added. I understand payment can be made at our office or through the mail. If you do not have insurance, payment of $125.00 will be collected at the time of service and the balance will be billed out at a 20% discount. If you choose to submit to insurance after the fact, prices may change. I have been given the HIPAA information from Family Urgent Care and understand the privacy policy regarding my rights.

Signature _____ **Date** _____