Consent to Treat
Demographics 18 & Under

PATIENT:
DOB:
ACCT #:

Reason for Todays Visit: ____

Patient Information 18 and Under

First, Middle, Last Name: ____

Address: ____________________________ Apt #: _____ City: ______________ State: ______ Zip: ___________

Primary Phone: (____) ________________________ Secondary Phone: (____) ______________________________

Date of Birth: ___________________________________ Gender: Male Female

Ethnicity: Hispanic Non-Hispanic Race: ____________________ Preferred Language:___ _____________________

Parent/Person Responsible for Payment

First, Middle, Last Name: ____

Address: ________________________________ Apt #: ______ City: ______________ State: ________ Zip: _________

Primary Phone: (____) ____________________________ Secondary Phone: (____) _________________________

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

Social Security #: _______________ Employer: _______________________ Employer Phone: (____)_______________

____

Primary Insurance

Insurance Company Name: __________________________ ID#: ______________________ Group#: ________________

Policyholder's Name: _________________ Patient's Relationship to Policyholder: ☐Self ☐Child 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 ☐Child 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 the patient's medical information to:**

Name: ________________ Date of Birth: ________ Phone#: (____) ____________ Relationship to Patient: __________

☐ **No other people authorized to receive information. OR** ☐ **The following person is authorized:**

Name: _________________ Date of Birth: ________ Phone#: (____) ____________ Relationship to Patient: __________

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 vary. I have been given the HIPAA information from Family Urgent Care and understand the privacy policy regarding my rights.

Signature_____________________________________ **Date** _______________________________

Relationship to Patient: ☐**Parent** ☐**Legal Guardian** **Other** ___________________________