SPRINGS URGENT CARE

PLEASE PRINT

PATIENT FIRST NAME_____ MI_____ LAST NAME_____

SS#_____-_____-_____ DOB_____GENDER ___M___F MARITAL STATUS_____

EMPLOYER_____ HOW DID YOU HEAR ABOUT US?_____

PATIENT ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

HOME PHONE_____ CELL PHONE_____

EMAIL ADDRESS_____

EMERGENCY CONTACT (OTHER THAN SPOUSE)_____

RELATIONSHIP_____ PHONE_____

INSURANCE SUBSCRIBER INFORMATION:

NAME_____ DOB_____ SS#_____

EMPLOYER:_____ RELATIONSHIP TO PATIENT_____

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 judgement 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 ant 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 interest based on our professional judgment to disclose such PHI information necessary.

I 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