Date: _____/____/_____

Demographics – 7/21

PATIENT INFORMATION

Name:_____ DOB:_____/_____/_____
First *M.I.* *Last*

Address:_____ Apt#:_____ Phone #:_____-_____-_____

City:_____ State:_____ Zip: _____ Pharmacy:_____

POLICY HOLDER/RESPONSIBLE PARTY INFORMATION *(If same, as above – leave blank)*

PATIENTS OVER THE AGE OF 18 WILL BE THEIR OWN RESPONSIBLE PARTY.

Name:_____ Relationship to Patient:_____

Address:_____ Apt#:_____

City:_____ State:_____ Zip Code:_____

EMAIL

Lab Results and Billing Statements are sent to the Patient Portal. **Your email is required for the portal.** PUC does not share/sell emails.

_____ @ _____ . _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship:_____ Phone#:_____

Signature of Patient or Parent/Guardian: _____ Date: ____/____/___

Date: _____/____/_____
Patient Name: _____

Release of Information – 7/21

AUTHORIZATION TO RELEASE MEDICAL/FINANCIAL INFORMATION

In accordance with HIPAA, Physicians Urgent Care (PUC) can only give copies of your financial information, condition, exams, procedures, and/or x-rays with individuals who you designate other than your primary care doctor or specialist. We must obtain your authorization for this. In the event you are unable to give authorization due to the severity of your medical condition, the law stipulates these rules may be waived.

☐ I DO NOT authorize PUC to release any information concerning my care to any individual.
☐ I authorize PUC to release any/all medical/financial to the following individual(s):

Name: _____ Relationship:_____ Phone#:_____
Name: _____ Relationship:_____ Phone#:_____

AUTHORIZATION TO LEAVE PHONE MESSAGE

☐ I authorize PUC to leave a detailed messages at phone number: _____-_____-_____

☐ I DO NOT authorize PUC to leave a detailed message on my voicemail. I acknowledge in choosing that option that I, the patient/guardian, assume full responsibility for contacting PUC regarding any/all testing results.

CONSENT TO WIRELESS TELEPHONE CALLS

If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payments for items and services, unless I notify Physicians Urgent Care to the contrary in writing.

RECEIPT OF HIPAA PRIVACY NOTICE

I acknowledge the Notice of Privacy Rights with detailed information about how PUC may use my protected health information is available on their website at *physiciansurgentcare.com* by clicking *HIPAA*. I understand that PUC reserves the right to change the privacy notice and that a copy of the revised notice is always available on our website.

BILLS OUTSIDE OF PUC

Physicians Urgent Care utilizes Pathgroup and Williamson Medical Center for lab testing that is not performed in house. Imaging beyond x-ray is also referred to third-party facilities. Patients will receive a separate bill from any third-party laboratory or imaging facility as they are separate entities from Physicians Urgent Care.

PAYMENT AND BILLING INFORMATION

At each visit, Physicians Urgent Care will collect payment based on an individual's insurance plan. **Payments are collected at check-in and may include co-pays or flat rate fees.** A claim will be filed with your insurance company. If the insurance company's patient responsibility differs from the initial payment, the difference will be either charged or refunded to the card we have on file. Patients will be notified through text and email five days prior to the card being charged.

CREDIT CARD ON FILE

I authorize Physicians Urgent Care to keep my signature on file beginning on _____ and to charge my credit/debit card for the balance of charges related to all transactions after insurance responsibility has paid. Charges will not exceed an amount of $300 per date of service. If I am the guarantor of the patient, my signature authorizes PUC to charge my card for balances associated with this patient's account.

Signature of Patient or Parent/Guardian: _____ Date: ____/____/___