URGENT CARE
of Berwick, Midtown, Sandfly, & Wilmington Island

## *Patient Information*

**Today's Date: _____ Patient's Gender: _____ Patient's Date of Birth: ____/____/_____ Patient's Age:___**

**Patient's Last Name: _____ Patient's First Name: _____Patient's Middle Name: _____**

**Patient's SSN# _____-_____-_____ Patient or Legal Guardian's E-mail Address: _____**

**Patient's Street Address: _____ Building/Apartment #: _____**

**City: _____ State: _____ Zip: _____**

**Home #:** (_____) _____-_____ **Work #:** (_____) _____-_____ **Cell #:** (_____) _____-_____

**Patient's Employer: _____**

**Race (Circle all that apply):** American Indian or Alaska Native Asian African American or Black

Hispanic or Latino/a Native Hawaiian or Other Pacific Islander White Unknown

**Is the patient of Hispanic or of Latino/a Decent? (Y/N) _____**

**Primary Care Physician: _____ Phone Number: _____**

**Patient's Marital Status: (Circle One)** Single Married Divorce Separated Partnered Widowed

***Emergency Contact*: _____ *Relationship to Patient*: _____**

***Emergency Contact Phone #:* _____ E-Mail Address: _____**

### *Insurance Information*

**Primary Insurance: _____**

**Subscriber's Name: _____**

**Subscriber's Date of Birth: _____/_____/_____**

**Subscriber's SSN: _____-_____-_____**

**ID #: _____**

**Group #: _____**

**Secondary Insurance: _____**

**Subscriber's Name: _____**

**Subscriber's Date of Birth: _____/_____/_____**

**Subscriber's SSN: _____-_____ _____-_____**

**ID #: _____**

**Group #: _____**

*Continue to next page.*

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**Reason for today's visit:** _____

_____

**For Worker's Compensation or Motor Vehicle Accidents ONLY:**

*(If this does not apply to you, please proceed to the bottom of this page.)*

**If Injured: Were you injured on the job? (Y/N)** _____ **Injury Date:** _____

**Were you injured as the result of a car accident? (Y/N)** _____ **Injury Date:** _____

If you were injured on the job, please have your employer complete the Workers Compensation Form. If you would like us to email to an employer, please include their information below:

**Employer Name:** _____

**Employer E-mail:** _____ **Employer Phone Number:** _____

**Patient Signature or Signature of Responsible Party:** _____

**If you are not the patient, please print your full name:** _____

**Relationship to Patient:** _____ **Date:** _____/_____/_____

Please provide the Medical Receptionist with your insurance and ID.

If you are not using insurance for this visit, please present the Medical Receptionist with your ID.

(For patients under 18 years of age, please use ID of parent or legal guardian.)

*Continue to next page.*

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# Authorization for Treatment

I authorize the physician and staff of Urgent Care of Your Family Medical Group to treat myself or the person for whom I have responsibility. I understand that this consent to treat includes my consent for medical test, procedures, drugs and other services and supplies as considered advisable; and may include, but is not necessarily limited to: anesthesia, pathology, radiology, and other imaging and diagnostic services, and other special test and services including tests for communicable diseases and toxins, as ordered by the physician responsible for my care during my visit to Your Family Medical Group. I acknowledge that the practice of medicine is not an exact science and no guarantees or promises have been made to me as to the results of examination, care, or treatment at Your Family Medical Group. I acknowledge that it is important for me to provide accurate and complete information regarding my symptoms, medications, drug use, and other information, and that failure to do so can adversely impact my care. I understand I may request a copy of Your Family Medical Group's Notice of Privacy Practices to read and/or take home with me at any time. I understand that if I want more information about these privacy practices or have questions or concerns, I may ask the Center's staff or contact Your Family Medical Group as indicated on the notice.I authorize Your Family Medical Group, or its agents, to release medical or other information to my insurance company, the Center for Medicare and Medicaid Services, or its carriers, as necessary to determine payment for these or related services.

I request that payment authorized by my insurance company, the Center for Medicare and Medicaid Services, or its carriers, be made on my behalf to Your Family Medical Group for services provided by said group. I certify that any information I provide related to my eligibility for coverage or payment is accurate and complete. I understand that I am required to notify Your Family Medical Group of any change in insurance Coverage. I understand I am financially responsible for payments of services provided during the visit if I do not have insurance coverage or if I have coverage and timely payment is not made. I also understand that if I have a co-payment for this service, it is payable today. I understand that I am responsible for paying the amount of any discount imposed if my insurance provider or third- party payer imposes a discount, which are not authorized by a signed agreement between that payer and Your Family Medical Group **Certain lab tests may be sent to an independent lab for processing. I understand I may receive a separate bill for these services. Your Family Medical Group utilizes LabCorp for all Send Out labs. Radiology services may result in an additional bill from the Radiologist from Coastal Imaging and any specialty orthopedic products will be billed by DJO, LLC.** Some insurance companies require preauthorization for certain services. If I am required to obtain an authorization for today's visit and have not done so, I agree to assume all financial responsibility. If I receive any additional services from specialists, hospitals, or other healthcare providers in connection with or because of this visit, those charges may also be my responsibility, unless preauthorized as required by my insurance company. I understand and agree that invoices for patient balances due may be emailed directly to the email address provided on registration. If collection procedures are initiated on any outstanding balance, I agree to be responsible for the costs of collection including, but not limited to court costs, expenses, and attorney fees, to the extent permitted by law. I understand that the foregoing provisions apply equally to any individual for whom I am authorized to consent to treatment, or for whom I qualify as an authorized representative or authorized agent under any laws.

_____**Date:** _____

***Patient's or Parent/Legal Guardian Signature***

_____**Patient's Date of Birth:** _____

***Patient's Name (please print clearly)***

**If you are not the patient, please complete the following:**

**Full Legal Name:** _____

**Relation to Patient:** _____ **Are you the patient's legal guardian?** (Y/N) _____