Kerrville URGENTCARE

Patient Information

☐ **New Patient** ☐ **Existing patient**

Check in Time: _____ Check in Date: _____

Patient's Full Name: _____

Reason for Visit: _____ Is this work related? Yes No

Date of Birth: _____ Gender: ☐ Male ☐ Female

Social Security#: _____ Ethnicity/Race_____

Marital Status: Single Married Widowed Separated Divorced

Mailing Address: _____

City: _____ State:_____ Zip: _____

Phone: Home: _____ Cell: _____ Work:_____

Email Address: _____

Primary Care Physician: _____

Employer: _____

Insurance Primary: _____ None

Insurance Secondary: _____

Pharmacy: _____ City: _____

Emergency Contact

In case of an emergency, who should be notified?

Name: _____ Phone: _____

Relationship: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I _____ have read this provider's Notice of
(Please Print your Name)
Privacy Practices, detailing how my information may be used and disclosed as permitted under Federal and State law. I understand the contents of the Notice, and I request the following restriction(s) concerning my personal medical information:

_____

_____

Other Permissions:

I authorize the following friends or relatives to get copies of my medical records (for a fee), and authorize them to discuss medical information about me over telephone or in person.

Please list those you authorize to get a copy of your medical records below.

(1) _____ (2) _____
(3) _____ (4) _____

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

_____

Signature Date

_____

Relationship to Patient

_____

Staff (Print) Staff Signature

_____

Date

Kerrville URGENT CARE

AUTHORIZATION AND AGREEMENT FOR TREATMENT

The undersigned hereby makes the following Acknowledgements and Agreements regarding emergency treatment to be provided to the patient whose name appears below:

1. **Consent to Treatment:** I understand that medical treatment of an urgent nature is necessary for the patient and that such medical care, treatment, and procedures will be performed by independent non-employee physicians and their assistant, during hours of operation. Independent non-employee physicians are not employees or agents of Kerrville Urgent Care. I understand that emergency treatment only is being provided, and that no responsibility will be taken for long-term care of the patient or care after hours of operation. I hereby grant my authorization and consent to such treatment and procedures, and certify that no guarantee or assurance has been made as to the results that may be obtained.

2. **Selection of Personal Physician:** I understand that if hospitalization or further treatment is required, Kerrville Urgent Care will attempt to contact the patient's personal physician to provide this service. If the patient does not have a person physician or the personal physician cannot be contacted, the Urgent Care's independent non-employee may select another physician to provide this care.

3. **Agreement to Pay at Time of Services:** For and in consideration of the care and treatment provided to the patient, I promise to Kerrville Urgent Care all charges for services rendered to or on behalf of the patient.

4. **Release of Medical Information:** I hereby authorize Kerrville Urgent Care to release any medical information in connection with these services for health insurance purposes or to the patient's personal physician, or to the patient's employer in the event of a Worker's Compensation injury, or according to the clinic's privacy policy.

5. **Assignment of Release:** I hereby give lifetime authorization for payment of Insurance benefits to be made to Kerrville Urgent Care and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

I have read the above Acknowledgement and Agreement, and fully understand the same.

Signature: _____ **Date:** _____
Relationship to Patient: _____
Witness: _____ **Date:** _____

Telephone Permission Granted By: _____
Witness: _____ **Date:** _____
Witness: _____ **Date:** _____