

Check in Time: \_\_\_\_\_

Check in Date: \_\_\_\_\_



### Patient Information

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

How did you hear about us? \_\_\_\_\_

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: \_\_\_\_\_

## 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 personal 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 privacy notice:** 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.

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 bellow.

(1) \_\_\_\_\_ (2) \_\_\_\_\_  
(3) \_\_\_\_\_ (4) \_\_\_\_\_

**I have read the above Acknowledgement and Agreement, and fully understand the contents of the Notice, and I request the following restriction(s) concerning my personal medical information:**

\_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Relationship to Patient:** \_\_\_\_\_  
**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_

For more information see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html)