Welcome To Premier Urgent Care Center

Section I: Patient Information Today's Date_____

Last Name:_____ First Name:_____ I Prefer to be called: _____
ResidenceAddress:_____City:_____State:_____Zip_____
Mailing Address:_____City:_____State:_____Zip_____
Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____)_____
Date of Birth:_____ Social Security Number:_____ Sex ☐ M ☐ F
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Email Address_____ Language Preference_____
email address will **not be shared with 3rd party vendors*
Employer:_____ Address:_____Work Phone (____)_____

The best time to contact me is:_____ ☐ AM ☐ PM on my ☐ Home phone ☐ Work phone ☐ Cell phone
Person to contact in case of emergency:_____ Relationship to Patient:_____
Phone(_____)_____

How did you hear about us: ☐ Internet ☐ Yellow Pages ☐ Drive by Signage ☐ Direct Mail ☐ Newspaper ☐ Word of Mouth ☐ Pharmacy ☐ Other

Section II Person Financially Responsible For This Account

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other ☐ Check if same as above
Name:_____ Relationship to Patient: _____
Address:_____
City:_____ State:_____ Zip:_____ Phone: (____)_____
Employer_____ Work Phone (____)_____ SSN#_____

Section III Insurance Information

Primary Insurance Company Name:_____ ☐ Check if Self Pay
Secondary Insurance Company Name:_____
Workers Compensation Claim Number:_____ Date of Injury:_____
**if this visit is related to a work injury/accident*
Motor Vehicle Insurance Name:_____ Date of Accident:_____
**if this visit is related to a car/motorcycle accident*

Name of Insured_____DOB_____Relationship to Patient _____

Lifetime Assignment of Benefits / Information Release / Authorization to Treat:

I authorize payment of medical benefits to Premier Urgent Care for any services furnished. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize you to release to my insurance company or its agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits. I fully understand that it is impossible to guarantee copays, deductibles and coinsurance amounts. If my insurance company sends Premier Urgent Care an Explanation Of Benefits reflecting a higher copay, deductible and/or coinsurance, it will be my responsibility to satisfy the difference. If I submit a receipt to my insurance company for reimbursement purposes and my insurance pays Premier Urgent Care I may be due a refund. However, I will be subject to the refund policy of Premier Urgent Care (a copy of our refund policy is available upon request).

I also authorize the Interdisciplinary team to perform the treatments or procedures approved by my referring physician. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.

I also authorize the release of test data and insurance information to a licensed physician of the facility's choosing for the purposes of professional interpretation and establishment of a diagnosis and treatment recommendations.

I have read and fully understand my HIPAA Patient Rights and Responsibilities and this facility's Patient Concern Procedure.

Patient Signature:_____ Date:_____

**Parent or Guardian Signature (if child is under 18 years old)*