EAGLE FORD URGENT CARE ADMISSION FORM

Description of Injury/Symptoms_____ ☐Insurance ☐SelfPay ☐Work Related

_____

PATIENT INFORMATION

Name (Last, First, Middle)_____ Social Security # _____

Sex ☐M ☐F Age_____ Birth Date _____ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Address_____ City _____ State _____ Zip _____

Home Phone_____ Mobile/Work Phone _____ Preferred: ☐Home ☐Mobile/Work

Email_____ How did you hear about us? _____

Patient Employed By_____ Supervisor _____

Primary Care Physician_____ Phone # _____

In case of Emergency (Name, Phone, Relation)_____

PATIENT/GUARANTOR INFORMATION

Name (Last, First, Middle)_____

Social Security # _____ Sex ☐M ☐F Age_____ Birth Date _____

Address_____ City _____ State _____ Zip _____

Home Phone_____ Mobile/Work Phone _____ Preferred: ☐Home ☐Mobile/Work

Email_____ Relationship to Patient: ☐Parent ☐Guardian ☐Spouse ☐Employer

PRIMARY INSURANCE

Carrier_____

Subscriber ID _____ Group # _____

Insurance Claims Address_____

Phone _____

Policy Holder Name_____

Social Security # _____ Sex ☐M ☐F

Birth Date _____

Relationship to Patient: ☐Parent ☐Guardian ☐Spouse

SECONDARY INSURANCE

Carrier_____

Subscriber ID _____ Group # _____

Insurance Claims Address_____

Phone _____

Policy Holder Name_____

Social Security # _____ Sex ☐M ☐F

Birth Date _____

Relationship to Patient: ☐Parent ☐Guardian ☐Spouse

AUTHORIZATION AND RELEASE

Authorization of Treatment: I voluntary consent to the administration and cost of medical and surgical procedures, x-ray and medication for myself and my dependents

Assignment of Insurance Benefits: I authorized payment directly to this urgent care center for all benefits otherwise payable to me.

Guarantee of Payment: I understand that I am financially responsible and agree to pay all of the charges that are not paid or billed to insurance or any other third party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance co-pays, coinsurances and deductibles today. If you are unable to verify my insurance at time of service, I will pay in full for all services.

Release of Records: I authorize this urgent care center to release (verbal or in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or other health care operation which may be liable to me or my practitioner(s) for charges for this treatment and for quality management, utilization review, transfer and follow-up purposes.

Receipt of Privacy Practices: I acknowledge that a copy of the Notice of Privacy Practices of Complete Urgent Care is available to me upon request and is also available on our website.

I understand that a copy of this agreement may be used with the same effectiveness as the original.

Patient Signature _____ Date_____

Responsible Party (Parent/Guardian) _____ Date_____