SIGNATURE URGENT CARE

Reason for Visit: (Please advise staff if this visit is work or auto accident related injury/illness)	Today's Date: / /

PATIENT INFORMATION:

Patient's Last Name:	First Name:	Middle:

Sex: ❑ M ❑ F	Date of Birth: / /	Age:	❑ Mr. ❑ Ms. ❑ Mrs. ❑ Dr.	Marital Status Single / Mar / Div / Sep / Widow

Patient Address:	City:	State:	Zip Code:

Social Security Number:	Cell Phone Number:	Email:

Occupation:	Employer:

Chose clinic because (please check one box)

❑ Google ❑ Facebook ❑ Yelp ❑ Postcard/Flyer ❑ Family/Friend ❑ Advertisement ❑ Close to home/work ❑ Insurance Plan

❑ Other _____

EMERGENCY CONTACT (REQUIRED)

Name:	Relationship:	Phone:

PREFERRED PHARMACY (REQUIRED)

Pharmacy Name and Location (Cross Streets):	**OR** ❑ Closest Publix Pharmacy (1 Block away from this clinic) ❑ Closest CVS Pharmacy (1 Block away from this clinic)

INSURANCE POLICY HOLDER INFORMATION

Name:_____ Date of Birth:_____/ /_____

Address:_____

Please complete back side

"Serving our community 7 days a week!"

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MEDICATION LIST

(IF YOU HAVE A MEDICATION LIST, PLEASE PROVIDE TO FRONT DESK INSTEAD)

❑ **NOT TAKING ANY MEDS**

I AM TAKING:	DOSAGE/mg:	TIMES PER DAY	REASON FOR TAKING:
1.			
2.			
3.			
4.			
5.			

❑ **NO KNOWN MEDICATION ALLERGIES**

I AM ALLERGIC TO:	TYPE OF REACTION (RASH, NAUSEA, ETC.)
1.	
2.	
3.	
4.	

CONSENT FOR TREATMENT, GUARANTEE OF PAYMENT, NOTICE OF PRIVACY PRACTICES, AND RELEASE OF INFORMATION

• I consent to evaluation and treatment by Signature Urgent Care physicians and health care providers. I understand that my treatment and care may include routine care, such as immunizations, and a variety of other medical services depending on my condition, such as laboratory testing and x-ray. This consent will be effective for 1 year after the date it is signed at Signature Urgent Care or until I am a patient at Signature Urgent Care.

• I give permission to Signature Urgent Care providers and other staff members to release any information about me, my health, the health services provided to me, or payment for my health services, that may be necessary:

- o For my treatment to other health care providers or facilities that need the information for my continued care;
- o For any payment related matters to insurance companies or third parties and/or related entities.

• I agree to allow Signature Urgent Care employees and affiliates to leave text or voice message on the numbers I have provided.

• I hereby authorize payment directly to Signature Urgent Care for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I hereby authorize Signature Urgent care to utilize my cell phone &/or e-mail address for the purposes of billing notification and e-statement delivery.

• I hereby acknowledge that I have received and read a copy of Signature Urgent Care's **HIPAA: Notice of Privacy Practices**. (If you wish to review standard Privacy Policy, see binder at front desk).

• Fees incurred in collection or litigation of any unpaid balances will become the responsibility of the patient or guarantor. I irrevocably assign my benefits to Signature Urgent Care including the right to sue my insurance company for denials or reductions. **I also agree that if a referral is needed by my primary doctor, it is my responsibility to obtain it.** I authorize the above medical provider to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

The above information is true to the best of my knowledge.

PATIENT/GUARDIAN SIGNATURE

X _____

Date

_____ / / _____

"Here For You When You Need Us"

7 Days A Week!