URGENT CARE OF MOUNTAIN VIEW

Please present your insurance card at time of check-in. Payment of patient financial responsibility is expected at time of service.

REASON FOR VISIT: ☐ Insurance (present card at check-in) ☐ Self-pay (payment due at time of service)

☐ On-the-job injury ☐ Auto Accident ☐ Other: _____

Patient Name: Last: _____ First:_____ Middle Initial: _____

Date of Birth: _____/_____/_____

Social Security Number: _____ Sex: ☐ M ☐ F

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Address : _____

City _____ State_____ ZIP _____

Home Phone: ☐ Preferred ( )_____Cell Phone: ☐ Preferred ( ) _____
Work Phone: ☐ Preferred ( ) _____

Emergency Contact: _____ Phone #:_____

Relationship: _____

May we leave a message regarding your care (x-ray, lab results) on your preferred phone? ☐ Y ☐ N

Is this an on-the-job or other work-related injury? ☐ Y **STOP** Please complete below ☐ N

Date of Injury: _____/_____/_____

Employer Name: _____

Supervisor: _____

Street Address: _____

City, State, ZIP _____ _____ _____

Description of Injury or Symptoms: _____

Parent or Guarantor's Name: Complete with name of insured if the patient is not responsible for charges today.

Last:	First:	Middle Initial
Date of Birth: _____/_____/_____	Social Security Number:	Sex: ☐ M ☐ F

Street Address:			
City	State	ZIP	
Home Phone:	Work Phone:		
Employer:			

Insurance Information: Please notify staff if secondary insurance should be billed.

Carrier:	Subscriber ID	Group Number:
Policy Holder Name:		DOB:

Primary Care Physician: _____ _____

First Name *Last Name*

Should we fax or mail a copy of your chart? Y N

Authorization and Release Authorization For Treatment: I voluntarily 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 authorize 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 copays, 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 operations 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 I have received and read the Notice of Privacy Practices of this urgent care center.

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

PATIENT SIGNATURE _____ DATE _____/_____/_____

RESPONSIBLE PARTY _____ DATE _____/_____/_____

REVIEWED BY _____ DATE _____/_____/_____