



Welcome to our office, thank you for choosing us.

In order to serve you properly we will need the following information filled out completely. (Please print.)

PATIENT INFORMATION:

LAST NAME: FIRST NAME MI: ADDRESS: APT. #: CITY: STATE: ZIP: HOME PHONE: PERSONAL E-MAIL ADDRESS: WORK PHONE: CELL: D.O.B.: SSN#: AGE: MALE FEMALE MARITAL STATUS: MARRIED SINGLE WIDOWED DIVORCED SEPARATED EMPLOYER: WORK PHONE: EMPLOYER ADDRESS: CITY: STATE: ZIP: EMERGENCY CONTACT: RELATIONSHIP: PHONE:

INSURANCE INFORMATION:

NAME OF INSURANCE: ADDRESS: CITY: STATE: ZIP: POLICY / ID # GROUP #: Co-PAY : \$ POLICY HOLDER NAME: RELATIONSHIP: D.O.B.: SSN#: AGE: MALE FEMALE ADDRESS (if different than patients) CITY: STATE: ZIP: PHONE: POLICY HOLDER'S EMPLOYER NAME: EMPLOYER PHONE: ADDRESS: CITY: STATE: ZIP:

{ I (Patient) have been informed that my insurance is out of network. Pt's Initials }

Do you have a secondary insurance (check one) { YES { NO

If patient is a minor, who may authorize treatment? Relationship: SS # of Guardian Phone:

Is Guardian address same as patient Yes / No (If No then we need Guardian to fill out separate information form)

Do you authorize this office to discuss your care or treatment with any party besides yourself: Yes/ No Spouse Other

I hereby authorize Advanced Urgent Care to provide medical treatment and/or to release any information acquired in the course of my examination or treatment to referring physician ( including your primary doctor) or insurance carrier listed above upon request.

AND

FINANCIAL AGREEMENT

I acknowledge full responsibility for all charges incurred, regardless of possible insurance coverage. I hereby authorize Advanced Urgent Care to obtain on my behalf, any insurance information covered by "The Privacy Act" from my insurance company(s) file(s). I hereby authorize payment directly to the physician(s) for medical and/or surgical benefits or auto accident. I FURTHER AGREE TO PAY 1.5% PER MONTH INTEREST FOR ANY OUTSTANDING BALANCES. IF THE ACCOUNT IS FORWARDED TO A COLLECTION AGENCY A 35% FEE WILL BE CHARGED, IN ADDITION TO ATTORNEY FEES, AND OTHER COLLECTION COSTS THAT MAY BE INCURRED TO ENFORCE COLLECTION OF ANY AMOUNTS OUTSTANDING. Balances of \$5.00 or less will not be billed but will remain on account for later collections.

Print Patient or Legal Guardian: Date:

Signature of Patient or Legal Guardian: Date:



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## GUARDIAN INFORMATION

FOR PATIENT: \_\_\_\_\_  
INSERT PATIENT NAME ABOVE

### Guardian Information

LAST NAME: \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MI: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT.: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME

PHONE: (\_\_\_\_) \_\_\_\_\_ WORK PHONE: (\_\_\_\_) \_\_\_\_\_ CELL: (\_\_\_\_) \_\_\_\_\_

D.O.B.: \_\_\_\_\_ SSN#: \_\_\_\_\_ AGE: \_\_\_\_\_ MALE \_ FEMALE

MARITAL STATUS: \_ MARRIED \_ SINGLE \_ WIDOWED \_ DIVORCED \_ SEPARATED