ALLSOUTH URGENT CARE, INC.

Name: _____ ( ) Male ( ) Female Age: ___ Date of Birth: _____
(First, Middle, Last)

Race: ☐ American Indian ☐ Asian ☐ Black/African American ☐ White ☐ Decline

Ethnicity: ☐ Central American ☐ Cuban ☐ Dominican ☐ Hispanic or Latino/Spanish American
☐ Spaniard ☐ Latin American/Latin, Latino ☐ Mexican ☐ Not Hispanic or Latino ☐ Puerto Rican
☐ South American ☐ Decline

Address: _____ City, State, Zip Code: _____
Email Address: _____
Social Security Number: _____ Home Phone: _____ Cell Phone: _____
Employer: _____ Work Number with **Extension**: _____
Method of Payment for Today's Visit: ( ) Cash ( ) Check ( ) Credit Card | Married ( ) Single ( ) Divorced ( )
Reason for Visit Today: _____ Related to Work Accident?: ( ) Yes ( )No

RESPONSIBLE PARTY INFORMATION (IF OTHER THAN PATIENT)
Name: _____ Social Security Number: _____ Date of Birth: _____
Address: _____ City, State, Zip Code: _____
Relationship to Patient: _____ Home Phone: _____ Work Phone/Extension: _____
Employer: _____ Address: _____

INSURANCE INFORMATION
Name of Insurance Company: _____ Policy/Contract#: _____
Group#: _____ Effective Date: _____ Policy Holder Name: _____
Policy Holder Date of Birth: _____ Relationship to Patient: _____
Home Number: _____ Cell Number: _____ Address: _____
Name of Insurance Company: _____ Policy/Contract#: _____
Group#: _____ Effective Date: _____ Policy Holder Name: _____
Policy Holder Date of Birth: _____ Relationship to Patient: _____

HOW DID YOU HEAR ABOUT US? ❑ TV ❑ Internet ❑ Billboard ❑ Friend/Relative ❑ Other_____

IN CASE OF EMERGENCY, NOTIFY (other than responsible party) Name: _____
Phone: _____ Cell: _____ Relationship to Patient: _____

I authorize the release & disclosure of any/all of my medical & treatment records or reports to any other health care provider who may be of assistance, in the opinion of AllSouth Urgent Care and/or for assisting in any reimbursement or medical benefits to which patient may be entitled. I consent for the medical provider to access and print my current medication list. I allow fax transmittal of my medical records, if necessary. I further authorize and request that insurance payments be made directly to AllSouth Urgent Care should they elect to receive such payment. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

I acknowledge full financial responsibility for services rendered by AllSouth Urgent Care including those which may not be considered covered by my insurance policy. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges. I understand that I may incur additional fees from the lab after my visit today.

I authorize medical treatment by AllSouth Urgent Care physicians & personnel. Such treatment to include but not limited to injections, medications procedures as recommended by the physician. I understand there are possible side effects and complications associated with the different injections and medications that may be rendered.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization. This authorization is valid for one year.

Patient (or Guardian) Signature: _____ **Date:** _____

Please Complete Back of Sheet

AllSouth Urgent Care, Inc.
PATIENT CONTACT INFORMATION

Patient Name: _____ **Social Security Number:** _____

Any physician, staff employee or representative of AllSouth Urgent Care Clinic, Inc. has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications, or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment, and payment:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to AllSouth Urgent Care Clinic, Inc or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals, it may be subject to redisclosure by the individual(s).

Patient Signature: _____ **Date:** _____

NOTICE OF PRIVACY POLICIES ACKNOWLEDGMENT

This NOTICE OF PRIVACY PRACTICES ("Privacy Notice") provides information about how AllSouth Urgent Care Clinic, P.C., will use, release, and disclose my protected health information for treatment, payment and health care operations without the need for any additional or specific authorization. I acknowledge that I have received a copy of the Notice of Privacy Practices for AllSouth Urgent Care Clinic, P.C.

Patient Signature: _____ **Date:** _____