

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the USA Urgent Care Clinic to release information requested by my insurance company or worker's compensation carrier. I also authorize the USA Urgent Care Clinic to release information to any hospital or physician I may be referred to by this office.

Signature_____

Date_____

Relationship to Patient_____

ASSIGNMENT OF BENEFITS

I hereby authorize assignment and payment directly to USA Urgent Care Clinic major medical benefits due me.

I hereby agree to pay any and all charges that exceed or are not covered by my insurance.

Signature_____

Date_____

Relationship to Patient_____

WE REQUEST FEES FOR OFFICE SERVICES AND VISITS AT THE TIME THE SERVICE IS RENDERED

DEMOGRAPHIC SHEET
USA URGENT CARE CLINIC
SUITE 1175 TRP III
MOBILE, AL 36688

Date: _____

J #: _____

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

Address: _____

City: _____ State: _____ Zip: _____

Phone: () _____

Social Security #: _____ Birth date: _____ Sex: _____

Doctor to see here today: _____

Patient Employed at: _____ Phone # & Ext: _____

Spouse Name: _____

Spouse Employed at: _____ Phone # & Ext: _____

IF PATIENT IS A CHILD:

Father's Name: _____

Father's Employer: _____ Phone # & Ext: _____

Mother's Name: _____

Mother's Employer: _____ Phone # & Ext: _____

Referring Doctor: _____

Responsible Party: _____

Address: _____

City & State: _____ Zip: _____

Insurance Co.: _____ Group #: _____

Insured's Name: _____ Contract #: _____

2nd Insurance Co.: _____ Group #: _____

Insured's Name: _____ Contract #: _____

WORKMAN'S COMPENSATION ONLY:

Insurance Co. Name: _____ Injury Date: _____

Address: _____

City and State: _____ Zip: _____

Verified By: _____ Phone #: _____ Ext: _____

IN CASE OF EMERGENCY, NOTIFY:

Name: _____ Relationship: _____

Address: _____

City, State & Zip: _____

Phone: () _____

USA URGENT CARE

Name _____ Date _____ Birthdate _____

PERSONAL MEDICAL HISTORY – Check and indicate year of onset.		
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer Type _____
<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Emphysema/COPD
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Prostate
<input type="checkbox"/> Back problems	<input type="checkbox"/> Other	
PAST SURGICAL HISTORY – Check and specify year.		
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Hernia Repair
<input type="checkbox"/> Gall Bladder	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Heart Cath
<input type="checkbox"/> Open Heart	<input type="checkbox"/> Other	
FAMILY HISTORY – Check and indicate relationship.		
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Depression
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer Type _____
HABITS – Check and indicate amount/frequency.		
<input type="checkbox"/> Tobacco	<input type="checkbox"/> Special Diets	<input type="checkbox"/> Alcohol
<input type="checkbox"/> Past tobacco use Quit _____	<input type="checkbox"/> Regular exercise (3 X / week)	<input type="checkbox"/> Perform Self Breast Exams
PRIMARY CARE PHYSICIAN:		
MEDICATIONS:		
ALLERGIES:		
OTHER PERTINENT INFORMATION:		

USA URGENT CARE CLINIC

PATIENT INFORMATION

NAME _____

CITY _____

TELEPHONE (HOME) _____

SOCIAL SECURITY # _____

SEX: M ___ F ___ RACE _____

J# _____ DATE _____

ADDRESS _____

STATE _____ ZIP CODE _____

(EMERGENCY) _____

DATE OF BIRTH _____

REFERRING PHYSICIAN _____

MOTHER'S INFORMATION

NAME _____

CITY _____

TELEPHONE (HOME) _____

SOCIAL SECURITY # _____

PLACE OF EMPLOYMENT _____

ADDRESS _____

STATE _____ ZIP CODE _____

(WORK) _____ (EMERGENCY) _____

DATE OF BIRTH _____

ADDRESS _____

FATHER'S INFORMATION

NAME _____

CITY _____

TELEPHONE (HOME) _____

SOCIAL SECURITY # _____

PLACE OF EMPLOYMENT _____

ADDRESS _____

STATE _____ ZIP CODE _____

(WORK) _____ (EMERGENCY) _____

DATE OF BIRTH _____

ADDRESS _____

PRIMARY INSURANCE

NAME OF INSURANCE _____

SUBSCRIBER'S NAME _____

RELATIONSHIP TO PATIENT _____

CONTRACT NUMBER _____

POLICY NUMBER _____

GROUP NUMBER _____

MEDICAID NUMBER _____

STATE OF _____

SECONDARY INSURANCE

NAME OF INSURANCE _____

SUBSCRIBER'S NAME _____

RELATIONSHIP TO PATIENT _____

CONTRACT NUMBER _____

POLICY NUMBER _____

GROUP NUMBER _____

MEDICAID NUMBER _____

STATE OF _____

SPECIAL HANDLING OF INSURANCE CLAIMS: (if mailed to a special address)

PRIMARY INSURANCE ADDRESS

SECONDARY INSURANCE ADDRESS

USA URGENT CARE CLINIC

CONSENT FOR MEDICAL EXAMINATION AND TREATMENT OF MINOR

I give permission for _____ (child's name) born on _____ (d.o.b) to receive services at the University of South Alabama Urgent Care Clinic. I understand that he/she may receive examinations, tests and immunizations. I understand that I will be expected to follow plans that are mutually agreed upon between the health staff and me. I certify that I am the legal guardian and that I can exercise all parental rights for said child.

Signature of Parent/Legal Guardian

Date

PERSONAL REPRESENTATIVES ACTING ON BEHALF OF PATIENT

The following individual can also serve as personal representative for the child and may exercise all parental rights for _____ (child's name)

Name of Individual

Relationship to Child

Signature of Parent/Legal Guardian

Date

PERSONAL REPRESENTATIVES PHI MAY BE SHARED WITH

I authorize the University of South Alabama Urgent Care Clinic to share Protected Health Information (PHI) with the following individuals regarding the care and treatment of _____ (child's name).

Name of Individual

Relationship to Child

Name of Individual

Relationship to Child

Name of Individual

Relationship to Child

Signature of Parent/Legal Guardian

Date

USA URGENT CARE

Patient Name			
Date of Birth	/	/	J #

1. FINANCIAL RESPONSIBILITY

The undersigned, in consideration of medical services to be rendered by USA Urgent Care to the below-named patient, does hereby agree to pay USA Urgent Care on demand for said services and incidents on behalf of such patient.

Signature of Patient or Patient's Representative

Date

2. ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of medical and surgical benefits, including major medical attending to USA Urgent Care. I understand that I am personally responsible to USA Urgent Care for all charges and services.

Signature of Patient or Patient's Representative

Date

Printed Name of Patients Representative (if applicable)

Representative's Relationship to Patient (if applicable)