DRY CREEK URGENT CARE

Patient Information Sheet

Patient Information

Name: ______________________________ SSN____________________ DOB______________

Address: __________________________ City ____________ State ______ Zip Code _________

Home#__________________ Cell #___________________ Work#______________________

Driver's License: ______________________________ Email: ___________________________

Primary Language___________________________ Ethnic Group________________________

Guarantor Information (FOR MINORS)

Name: _________________________ SSN______________________ DOB_________________

Home Phone#______________________________ Cell Phone___________________________

Insurance Information (NOT THE NAME OF THE INSURANCE)

Primary Policy Holder Name: _____________________ SSN______________ DOB__________

Policy Effective Date ____________

Secondary Policy Holder: ______________________ SSN_______________ DOB___________

Policy Effective Date ____________

Emergency Contact Person

Name: ____________________________________ Relationship to Person _________________

Address ____

Cell Phone __________________________ Home_____________________________________

RELEASE OF INFORMATION

Dry Creek Urgent Care will release medical records and information to patient's primary care physicians only. Please list the name of your physician below.

______________________	______________________
Physician's Name	Phone Number

MEDICAL RECORDS RELEASE: I understand that this authorization includes all medical records or other information regarding my treatment, hospitalization, and/ or outpatient care for my condition, including psychological or psychiatric impairment, drug and/ or alcohol abuse, or Acquired Immuno-deficiency Syndrome (AIDS), or tests for infection with Human Immuno-deficiency virus.

1. I hereby give my authorization to DRY CREEK URGENT CARE to release medical records to other providers to the extent necessary to determine liability or eligibility for payments and benefits and to obtain reimbursement from insurance companies, health care service plans, worker's compensation carriers and other state and federal health insurance agencies.
2. I hereby give my authorization for DRY CREEK URGENT CARE to send or request my records to/ from physicians and/or hospitals to which I am referred or have been treated by

This authorization can be revoked at any time upon my written request.

Further use or disclosure to the information being released beyond the specific limits of this consent is prohibited

FOR DISCUSSION WITH FAMILY AND FRIENDS:

I hereby give authorization to release information and/or discuss my medical condition including my protected health information such as psychological or psychiatric impairment, drug and/or alcohol abuse, or Acquired Immuno-deficiency Syndrome (AIDS), or tests for infection with Human Immunodeficiency Virus (HIV) with person(s)/entities listed below:

______________________	______________________
Person/entity name	Relationship to Patient (or other) description
______________________	______________________
Person/entity name	Relationship to Patient (or other) description
______________________	______________________
Person/entity name	Relationship to Patient (or other) description

This authorization can be revoked at any time upon my written request.

FINANCIAL RESPONSIBILITY

ASSIGNMENT OF BENEFITS: I request that payment of authorized insurance companies be made on my behalf to DRY CREEK URGENT CARE for any services furnished to me by my physician (Barbara Morlan M.D., Tony Reid P.A.C.) I authorize any holder of medical information about me to release to the Health Care Financial Administration and its agent and/or any insurance my signature requests that payment be made and authorizes release of medical information necessary to pay this claim. In insurance carrier assigned cases, the physician or supplier agrees to accept the charge determination of the insurance carrier as the full charge, and the patient is responsible for the deductible, co –insurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the insurance carrier.

FINANCIAL AGREEMENT: I, undersigned, agree whether I am signing as an agent or as the patient, that I am financially responsible for any charges not covered by the insurance assignment(s). It is understood and agreed by all parties that if DRY CREEK URGENT CARE is contracted with my insurance carrier, I am only responsible for my co-payment and/or deductible as contracted. If there is no insurance coverage/ or eligibility, I will be responsible for all charges. Further, I understand that prescribed medication may not be covered by my insurance and that I am responsible for the cost.

Further use or disclosure to the information being released beyond the specific limits of this consent is prohibited.

Notice of Privacy Agreement (SEE BACK LAMINATE)

Dry Creek Urgent Care has provided the Notice of Privacy Packet on ____________________

Date

My signature acknowledges that I have read and understood this registry packet thoroughly and was given a personal copy of my Privacy Packet upon request.

______________________________	______________________________
Signature of Patient or Authorized Person	Relation to Patient
________________	______________________________
Date	Witness Signature