



1. Patient's demographic information

Patient Name (please print clearly): _____ Today's Date: _____

Social Security Number: ____ - ____ - ____ Date of Birth: _____ Gender: Male Female

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Marital Status: S M D Sep W

Reason for today's visit: _____

How did you hear about us? _____

2. Communication Preferences

May we call you: Yes No; May we leave a message: Yes No; Best time to call: Any AM PM

Who else may we speak with regarding this visit? _____

Primary Physician: _____ Phone: _____

May we fax your discharge sheet to your Primary Physician? Yes No Initials _____

3. Please complete section if insurance policy holder is different than the above named patient

Guarantor Name (print clearly): _____ Gender: Male Female

Relationship: _____ Social Security Number: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

If a guardian or patient representative completes this form, on behalf of the patient, please complete the following:

Representative Name (please print clearly): _____ Relationship: _____

4. Is this workman's comp? Yes No - If yes, please fill out the bottom section

Employer Name: _____ Position: _____

Address: _____ City, State, Zip: _____

Employer Phone: _____



Patient Name: _____ Date of Birth _____ Today's Date _____

5. HIPAA Privacy Act

Purpose: This section is used to document an individual's acknowledgement of receipt of our Privacy Practices Notice.

I acknowledge that I have read a Privacy Practices Notice from Urgent Care Center of Lancaster.

Patient or Representative (Circle One) Signature: _____

Print name if representative: _____

6. Assignment, Release, and Authorization Acknowledgement

As a service to you, we will file your insurance claim if you assign the benefits to our practice. If you are insured by a plan with which we do not have a prior arrangement, we will prepare and send the claim for you on an unassigned basis. This means the insurer may consider our practice an out-of-network provider and reimburse accordingly. Not all insurance plans cover all services. In the event your insurance plan determines a service is not covered, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

ASSIGNMENT: I assign payment of medical benefits to Urgent Care Center of Lancaster for services rendered.

RELEASE: I authorize release of necessary medical information to my insurance carrier/s for insurance payment.

AUTHORIZATION: I request and authorize treatments chosen by providers and employees of this practice. Insurance does not substitute for payment, but may allow me to be reimbursed for services rendered. My insurance may have fixed allowances or percentages based on my contract.

Co-pays are to be paid **prior** to being seen by a provider.

YOU ARE RESPONSIBLE FOR CHECKING WITH YOUR INSURANCE COMPANY PRIOR TO SERVICES BEING PROVIDED FOR INFORMATION ON COVERAGE

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Patient/Representative (Circle One) Signature: _____