PATIENT INFORMATION			
SSN:		HOME PHONE:	
FIRST NAME:		CELL PHONE:	
LAST NAME:		EMAIL ADDRESS:	
MIDDLE NAME:		May we contact you by email? YES/NO	
DATE OF BIRTH:	SEX: MALE / FEMALE	MARITAL STATUS: SINGLE / MARRIED	
ADDRESS:	CITY:	STATE:	ZIP CODE:
EMPLOYER:	EMPLOYER PHONE NUMBER:		
DO YOU CONSENT TO HAVE VACCINES REPORTED TO THE NATIONAL VACCINE REGISTRY? YES/NO	RACE:	PREFERRED LANGUAGE?	HISPANIC/LATINO? YES / NO

EMERGENCY CONTACT:		
NAME:	RELATIONSHIP:	PHONE NUMBER:

HOW DID YOU HEAR ABOUT US:

PERSONAL INSURANCE COVERAGE			
Primary Insurance:		**Secondary Insurance:**	
NAME OF POLICY HOLDER:		NAME OF POLICY HOLDER:	
POLICY HOLDERS SSN:	DOB: / /	POLICY HOLDERS SSN:	DOB: / /
RELATIONSHIP TO PATIENT:		RELATIONSHIP TO PATIENT:	

GUARANTOR'S INFORMATION:			
FIRST NAME:	LAST NAME:	DOB: / /	SSN:
ADDRESS:	CITY:	STATE:	ZIP CODE:

CONSENT FOR TREATMENT: MedNOW Urgent Care and their employees will evaluate and treat the above patient for medical complaint and illnesses. This includes taking of medical information, evaluation by physical examination, obtaining of bodily fluids for laboratory testing, obtaining of X-rays for diagnosis, the administration of medications for treatment, and any other treatment or evaluation that may be necessary. If, at any time, I do not wish to have these services rendered, I may state so and they will not be provided, but an ABN form may need to be signed by the patient. All of my information will remain confidential. I acknowledge that I have been offered a copy of MedNOW Urgent Care Notice of Privacy Practices. _____initials

ASSIGNMENT OF BENEFITS: I authorize the release of any medical information and payment of medical benefits to MedNOW Urgent Care for services necessary to process this claim and any future claims. I agree to be responsible for any deductible, co-insurance, co-pay, or any other balance not paid by my insurance. _____initials

FINANCIAL POLICY: We are committed to providing you with the best possible medical care; if you have special needs, we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE: Co-payment will be collected before you are seen. Payment can be made by cash, check or credit card. If you have insurance that we do not participate with, our office will be happy to file the claim upon request; however payment in full is expected at the time of service. If you have questions about your insurance coverage, we will be happy to assist you. Specific coverage issues should be directed to your insurance company. It is however, understood and agreed that the Responsible Party is responsible for all monies due for services rendered in the event insurance does not pay for these services. ALL CHARGES ARE AN ESTIMATE AND FINALIZED WHEN YOUR INSURANCE COMPANY PROCESSES YOUR CLAIMS. BY INITIALING AND DATING BELOW, I UNDERSTAND THIS IS ALL TRUE AND EFFECTIVE FOR THREE YEARS FROM THIS DATE. _____initials _____DATE

If laboratory tests must be sent to an outside source for further evaluation, the responsible party understands they will be responsible for charges from that facility._____initials

When visiting our facilities After hours, nights and weekends a fee may be applied to the charges billed to your insurance company which is reasonable and customary in our contracts. _____initials

NOTE: It is company policy to run your check by EFT or your credit card. For private pays (no insurance) all charges for the visit are due before you are seen. Please note that you may have a balance at the end of your visit, which must be paid before you exit the clinic.

By signing below, I agree that I have read and understood the above terms of this agreement.

PATIENT/GUARDIAN (IF UNDER 18) **DATE**