**Cash: _____ Check: _____ CC: _____**

## PATIENT INFORMATION

**Reason for today's visit: _____**

**Car Accident? _____Yes _____No** **On the Job Injury? _____Yes _____No**

Date: _____ **How did you hear about us:** _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: __ _____

SS #: _____ Date of birth: _____ Sex: _____ Male _____Female

Home Phone: _____ Cell Phone: _____ E-Mail Address: _____

Primary Care Physician: _____

Name /address and phone number of employer: _____

## PRIMARY CARE INSURANCE

Insurance Company: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Policy Holder: _____ Relationship to Patient: _____

Policy #: _____ Group # _____ Guarantor Date of Birth: _____

## SECONDARY INSURANCE

Insurance Company: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Policy Holder: _____ Relationship to Patient: _____

Policy #: _____ Group # _____ Date of Birth: _____

## AUTHORIZATION AND RELEASE

**Authorization for Treatment**: I voluntarily consent to the administration and cost of medical and surgical procedures for myself or my dependent. **Assignment of Insurance Benefits:** I authorize payment directly to North Shore Urgent Care, PLLC for all benefits otherwise payable to me. **Guarantee of Payment:** I understand that I am financially responsible and agree to pay all charges that are not paid or billed to insurance or any other third party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance co pays, coinsurances, and deductibles today. If you are unable to verify my insurance at time of service, I will pay in full for all services. **Release of Records**: I authorize North Shore Urgent Care, PLLC to release (verbal or in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or other health care operations which may be liable to me or my practitioner(s) for charges for this treatment and for quality management, utilization review, transfer, and follow up purposes. **Receipt of Privacy Practices:** I acknowledge that I have received and read the Notice of Privacy Practices of North Shore Urgent Care, PLLC. I understand that a copy of this agreement may be used with the same effectiveness as the original.

**PATIENT SIGNATURE**: _____ **DATE:** _____

**PARENT/GUARDIAN SIGNATURE:** _____ _____ **DATE:** _____

## CONSENT FOR NOTIFICATION OF TEST RESULTS/MEDICAL INFORMATION

I give permission to North Shore Urgent Care to:

1. Leave message on my answering machine : (circle one) Yes/No Cell phone # _____
2. Follow- up phone calls or call backs in regards to care at North Shore Urgent Care using this phone# _____
3. Leave information with the following people _____

**PATIENT SIGNATURE:** _____ Date: _____