

**INSURED PATIENT DEMOGRAPHIC INFORMATION
TEXAS HILLS URGENT CARE CENTERS**

PLEASE PRINT LEGIBLY

Reason for today's visit: _____

If this is an injury, is it work related? YES NO

If this is an injury, is it a result of a motor vehicle accident? YES NO

Are your symptoms related to a dental problem, toothache or abscess? YES NO

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: _____
Date of Birth: _____ Gender: M F Social Security #: _____ Marital Status: _____
Phone number: Home _____ Cell _____ Work _____
Street Address _____ City _____ State _____ Zip _____
Mailing Address (if Different) _____ City _____ State _____ Zip _____

Preferred Language _____

Race

American Indian/Alaska Native Asian Black/ African American White Native Hawaiian/Other Pacific Islander

Ethnicity

Hispanic or Latino Not Hispanic or Latino More specific _____

RESPONSIBLE PARTY INFORMATION: (if different from above)

Last Name: _____ First Name: _____ Middle Initial: _____
Date of Birth: _____ Gender: M F Social Security #: _____ Marital Status: _____
Phone numbers: Home _____ Cell _____ Work _____
Mailing Address: _____ City _____ State _____ Zip _____
Relationship to the patient: _____
Name of Employer: _____ Phone number _____
Address: _____ City _____ State _____ Zip _____

INSURANCE POLICY HOLDER INFORMATION: (if different from responsible party)

Last Name: _____ First Name: _____ Middle Initial: _____
Date of Birth: _____ Gender: M F Social Security #: _____ Marital Status: _____
Phone numbers: Home _____ Cell _____ Work _____
Mailing Address: _____ City _____ State _____ Zip _____
Relationship to the patient: _____
Name of Employer: _____ Phone number _____
Address: _____ City _____ State _____ Zip _____

*****Please give us the name of an Emergency Contact:**

Name: _____ Phone#: _____

I certify that the information provided above is complete and accurate to the best of my knowledge.

Signature of Patient or Patient Representative

Date

PATIENT NAME: _____ **DATE OF BIRTH:** _____

How would you like to receive correspondences from Texas Hills Urgent Care Centers? (Please select all that apply)

U.S. Mail Phone E-mail Secure electronic communication

Please provide an email address so that we can better communicate with you.

EMAIL ADDRESS: _____

How did you hear about our clinic?

RADIO NEWSPAPER SPORTS PROGRAM TELEVISION WEBSITE DRIVE BY

BILLBOARD FAMILY/FRIEND MY DOCTOR LOCAL BUSINESS PHONE BOOK

OTHER _____ (PLEASE SPECIFY)

You have been given a copy of the Office Policies and Privacy Practices of Texas Hills Urgent Care Centers. By signing below, you acknowledge receipt and understanding of these policies. Please keep this copy for yourself for future reference.

Patient or Responsible Party Signature

DATE

PATIENT NAME: _____

DATE OF BIRTH: _____

TEXAS HILLS URGENT CARE CENTERS

Please read the following information carefully!

Our offices are independently owned and operated. We do not receive any government funding or subsidies to provide care to the public. Our office employs highly trained and educated staff and physicians in order to provide the highest quality and courteous care to our patients. We do our best to inform you of your financial responsibility and expect that payment from our patients be made today. If you do not have the intention of paying the amount of money determined to be your responsibility for services received today, do not sign this form and seek treatment elsewhere.

PAYMENT POLICY: If an insurance company that we are contracted with insures you, we will be verifying eligibility and benefits at the time of service. If you have a deductible that has not been met, office copay, or your plan requires you to pay a percentage of your visit (coinsurance), we will be collecting that amount today at the end of your visit. You must have a **CURRENT** insurance card present at the time of service. You must present this card to receive your insurance benefits. An inability to present a current insurance card will require that you pay for your office visit in full today. **UNINSURED AND OUT-OF-NETWORK INSURED PATIENTS:** Texas Hills Urgent Care Centers requires **PAYMENT IN FULL** at the time of service for patients whose insurance plans we do not accept. Our office also requires **PAYMENT IN FULL** for those patients who are uninsured. We offer at 25% discount on our billed charges if either of the above mentioned circumstances exist. **We reserve the right to file theft of service charges in the event you are unable to meet this obligation once you have received your medical treatment. Theft of Service is a CRIME. Our office accepts major credit cards, personal checks, and cash. We do not hold checks or accept postdated checks. If your check cannot be directly debited through TELECHEK today, you must have another form of payment available to avoid being prosecuted for theft of service.**

CONSENT FOR MEDICAL TREATMENT: I, knowing that I am suffering from a condition requiring diagnostic, medical or surgical treatment, do hereby voluntarily consent to procedures and care and to the medical, surgical, or other services given to me under the specific instructions of any physicians working in this facility, as necessary in their judgment. **I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as a result of the treatments or examination by our physicians.**

INSURANCE ASSIGNMENT AND RELEASE: I certify that I, and/or my dependent(s), have insurance coverage with the insurance company listed or given to our office, and assign directly, all insurance benefits, if any, otherwise payable to Texas Hills Urgent Care Centers for services rendered. I understand that I am financially responsible for all charges, whether or not paid for by insurance. I authorize my signature on all insurance submissions.

The physicians at the Texas Hills Urgent Care Centers may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable to related services. This consent will end 1 year from the date signed below.

HOW WILL YOU BE PAYING FOR TODAY'S OFFICE VISIT?

CASH CHECK CREDIT CARD EMPLOYER

Your signature below is an acknowledgment that you have read, understand and agree to the terms of payment policy, consent for medical treatment, and insurance assignment and release.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

DATE