

**UNINSURED 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: \_\_\_\_\_

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

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

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)

**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: \_\_\_\_\_

**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 TELECHECK 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.**

**OFFICE POLICIES AND PRIVACY PRACTICES:** 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.

**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 office policies.**

\_\_\_\_\_  
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

\_\_\_\_\_  
DATE