Welcome Back!

Please take a few minutes to update the following information.

PATIENT INFORMATION

Name:_____ DOB: _____

UPDATE ONLY IF CHANGED FROM LAST VISIT:

Address:_____Contact Phone #:_____

City: _____ State:_____ Zip: _____

REASON FOR YOUR VISIT

Please list your health concern: _____

_____

***Optional; you may fill out a medical release listing those we may speak to about your medical treatment. Form attached.**

MEDICAL RECORDS

***Required, please write your email to access your electronic medical records:**
Email: _____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Doctors Urgent Care for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

Fees incurred in Collection or Litigation of any unpaid balances will become the responsibility of the patient of guarantor. I irrevocably assign my benefits to Doctors Urgent Care including the right to sue my insurance company for denials or reductions

I authorize the above medical provider to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I also acknowledge that I have received a copy of Doctors Urgent Care's HIPAA form: "Notice of Privacy Practices" which has been updated.

Signature of Responsible Party:_____ **Date:**_____