Welcome Back!

Please take a few minutes to update the following information.

PATIENT INFORMATION

Name:________________________________ DOB: ____________ Date: __________

UPDATE ONLY IF CHANGED FROM LAST VISIT:

Address:________________________________Contact Phone #:__________________

City: __________________________ State:_________ Zip: __________________

REASON FOR YOUR VISIT

Please list your health concern: ____

____

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 DOCTOR'S URGENT CARE including the right to sue my insurance company for denials or reductions. ***I also agree that if referral is needed by my primary doctor, it is my responsibility to obtain it.***

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 as of September 2013.

Signature of Responsible Party:_________________________ **Date:**_____________