AFTEROURS URGENT CARE PATIENT INFORMATION

DATE: _____ REASON FOR BEING SEEN:_____
PATIENT NAME: _____ DOB: _____
ADDRESS: _____ APT#: _____
CITY: _____ STATE: _____ZIP: _____
CELL PHONE: _____ HOME PHONE: _____ SSN: _____
EMAIL: _____
MARITAL STATUS: _____ SEX (Circle one): Male / Female PRIMARY LANGUAGE: _____
RACE: _____ ETHNICITY: _____ HEIGHT:_____ WEIGHT:_____
MEDICATIONS: _____
DOCTOR/PCP NAME & ADDRESS: _____
PHARMACY NAME & ADDRESS: _____

ALTERNATIVE/EMERGENCY CONTACT: _____ PHONE: _____

PERSON(S) WE MAY SPEAK WITH REGARDING YOUR CARE OR BILLS: _____
We may share (Circle all that apply): Billing Information / Health Information
Via: Phone:_____ Email: _____ Other:_____
1st INSURANCE NAME & SUBSCRIBER: _____ (Card Copy Required)
2nd INSURANCE NAME & SUBSCRIBER: _____ (Card Copy Required)

How did you hear about AfterOurs Urgent Care? (please circle all that apply)

Postcard	Local Event	Building Sign	ER	Online Search:	Other:_____
Letter	Magnet	Friend/Family	Employer	Google	PCP:_____
Newspaper	Insurance	Pharmacy	Phonebook	Ask.com / yp.com / iTriage	Doctor (not PCP):_____
Radio	Billboard	Hotel	Groupon	FindUC.com / Yelp	

FINANCIAL: If you cannot pay balance in full within 60 days you must call (888) 541-3432 to be considered for any special arrangements. Accounts without special arrangements that are not paid in full within 60 days will be turned over to a 3rd party collection agency. Accounts sent to collections will receive a $75 collection fee to cover the cost for such actions and will receive negative activity on their credit report if left unpaid. Cancelled checks and checks returned for insufficient funds will be assessed a service charge of $50.

CONSENT TO TREAT: I voluntarily consent to medical treatment and procedures that may be performed on me during this visit. This includes, but is not limited to, medical, therapy, surgical care, x-rays, tests, medications, laboratory test(s), or other services, which may be ordered by a physician participating in my care.

COMMUNICATION: By providing AfterOurs, Inc. with your landline or cell phone number(s), you give express authorization to contact you at these numbers. This is to be in effect for all medical information/results from today forward unless otherwise specified by you, the patient.

ASSIGNMENT OF INSURANCE BENEFITS, PAYMENTS, AND RELEASE OF MEDICAL RECORDS: I hereby authorize payment of medical benefits to AfterOurs Urgent Care. I further authorize the release of any medical/surgical information necessary for determining the extent of third-party coverage and for processing an insurance claim on my behalf. I permit a copy of this authorization to be valid as the original. I understand that I am ultimately responsible for and agree to pay all charges and expenses of the clinic for services and supplies furnished to me which are not paid through benefits for prepaid healthcare, insurance plans, or medical assistance.

I, the undersigned, acknowledge that the information I have provided above is accurate to the best of my knowledge. I have read and understand the above mentioned policies. Also, I understand and accept the HIPAA Privacy Practice of AfterOurs, Inc. as well as the Financial Policy Explanation & Patient Agreement which is available in any of the AfterOurs clinic locations and at www.afteroursinc.com.

Patient Signature: X_____ Date: _____

If person signing this document is not the patient being seen, please complete the following:

Responsible Party **Responsible party please provide current address if different from patient!**

PRINT NAME: _____ SSN: _____
ADDRESS: _____ APT#: _____
CITY: _____ STATE: _____ ZIP: _____
CELL PHONE: _____ HOME PHONE: _____
EMAIL: _____
Responsible party, or Guarantor Signature:
X_____Date: _____