STATESBORO URGENT CARE

Statesboro Urgent Care

Date: _____

Reason for Visit: _____

Is this a WORK related problem?___YES ___NO or AUTO ACCIDENT related? ___YES ___NO

Last Name**:** _____ First Name**:** _____ M.I. _____

Address**:** _____

City**:** _____ State**:** _____ Zip Code**:**_____

Birth Date**:** _____ Age**:** _____ Sex**:** _____ Social Security # _____

Race**:** _____ Primary Language**:** _____ Hispanic**:** YES NO

Marital Status**:** Single Married Divorced Widowed

Phone Numbers: Home_____ **Cell:**_____

Employer: _____ Occupation: _____

Patient's Relationship to Insurance Subscriber (please circle one): Self Spouse Dependent Other

Subscriber Name (if different from patient): _____Subscriber Birth Date: _____

Is insurance subscriber's address is different from above ___YES___NO **If yes, please fill in below:**

Address**:** _____

City**:** _____ State**:** _____ Zip Code**:** _____

☐ **YES,** I would like to receive periodic health related e-mail correspondence ☐ **NO,** thank you

Email address:_____

Please list any impairment(s) (visual, hearing, or any other): _____

Family Physician: _____ Phone**:** _____

Were you referred by a physician: **YES NO** If so, please list their name _____

PLEASE LIST A PHARMACY OR CHECK ONE FROM THE LIST PROVIDED BELOW

NOTE: Please keep in mind the hours of the pharmacy when making your selection.

Pharmacy Name: _____ City: _____

Cross Roads: _____

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Statesboro Urgent Care
PATIENT CONSENT FOR TREATMENT AND FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize medical treatment as deemed necessary and appropriate by the physicians of STATESBORO Urgent Care and their employees participating in my care.

With my consent, **Statesboro** Urgent Care may use and disclose Protected Health Information (PHI), about me to carry out treatment, payment and healthcare operations. Please refer to the **Statesboro** Urgent Care **Notice of Privacy Practices** for a more complete description of such uses and disclosures.

With my consent, **Statesboro** Urgent Care may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment or healthcare operations, such as appointment reminder, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, **Statesboro** Urgent Care may relay any items that assist the practice in carrying out treatment, payment or healthcare operations such as appointment reminders, insurance items, statement reminders and any information pertaining to my clinical care, including laboratory results among others, to:

PLEASE LIST PERSON(S) THAT WE CAN SPEAK WITH ON YOUR BEHALF
(PLEASE LIST BOTH PARENTS OR GUARDIANS FOR MINOR PATIENTS)

Name	Relationship to Patient
Name	Relationship to Patient

With my consent, **Statesboro** Urgent Care may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment or healthcare operations such as long as they are marked.

With my consent, I authorize **Statesboro** Urgent Care to release medical information regarding the care and treatment I have received from this office to the physicians I have listed on the reverse side of this form.

I have the right to request that **Statesboro** Urgent Care restrict how it uses or discloses my PHI to carry out treatment, payment or healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I authorize payment of insurance benefits directly to **Statesboro** Urgent Care I understand that I am fully responsible for any medical or surgical charge incurred in the course of my treatment, co-pay, deductible, all other charges determined to be patient responsibility or other type of unpaid service in excess of any hospitalization or health insurance that might be applicable.

I hereby authorize my physician to release pertinent information to my health insurance companies required in the course of my examination or treatment.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Statesboro** Urgent Care has the right to decline to provide treatment to me.

By signing this form, I am consenting **Statesboro** Urgent Care use and disclosure of my personal health information to carry out treatment, payment and healthcare operations.

Patient OR Legal Guardian Signature	Date
Printed Name of Patient OR Legal Guardian	Witness