We Care & Carr Care
CLINIC

Patient Name:________________________ Address:______________________

Date of Birth:______/_______/______ City:_______State:____Zip:______

SSN:______-______-_________ Home Phone: (_____)_____-_____

Gender (*please circle one*): M F Cell Phone: (_____) _____-_____

Marital Status (*please circle one*): E-mail:_______________________

M S D W Emergency Contact:____________

Parent/Guardian Name: Relationship:__________________

___________________________________ Phone: (_____) ______-______

Pharmacy Preference & Address:____

Insurance Information

Primary Insurance:___________________ Secondary Insurance:______________

Policy Holder Name:_________________ Policy Holder Name:_______________

DOB:___/___/___SSN:_____-___-______ DOB:___/__/___SSN:_____-___-____

Address:_____________________________ Address:_________________________

City:_____________State:____Zip:______ City:____________State:____ Zip:____

Phone Number: (_____) ______-_______ Phone Number: (_____) ______-______

Relationship:_________________________ Relationship:______________________

I am the (*please circle one*): patient | patient guardian

By signing below, I understand that I am responsible for services that are considered non-covered expenses by my insurer.

Signature:____Date:_________________

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Patient Name:______________________________ Date of Birth:_____/_____/_____

<u>HIPPA</u>

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (**HIPPA**), I have certain rights to privacy regarding my Protected Health Information, I understand that the information can and will be use to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payors.
- Conduct normal healthcare operations such as quality assessment and physician certifications.

I understand that I may request in writing that you restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are required to agree to my requested restrictions, and if agreed, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I am the (*please circle one*):

patient | patient's guardian

Signature:________________________

Date:____________________________

Consent for Evaluation and/or treatment

By signing below, I ma giving my consent to the practice of Family Urgent Care for evaluation and/or treatment. Once I have been examined, I understand that I will be informed of any medically recommended diagnostic procedures and/ or treatments and given the option to accept or decline. **The consent will remain fully effective until it is revoked in writing. You can have the right at any time to discontinue services.**

I am the (*please circle the one*):

patient patient's guardian

Signature:________________________

Date:____________________________

Contact Information

Please list the person(s) with whom we can discuss your health information.

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