St. Camillus
URGENT CARE

Patient Personal/Confidential Data and Consent Form

Last Name_____First_____MI_____

Nickname_____

Address_____

City_____ST_____Zip_____

Home Phone_____ Work Phone_____

Mobile Phone_____ Social Security Number_____

Sex_____ Marital Status _____

Date of Birth_____

Emergency Contact_____ Phone_____

Name of Spouse/Parent_____ Social Security _____

Insured Information: Last Name_____ First Name_____

Address if Different from Above_____

DOB of Insured _____ Social Security of Insured_____

Contact Number of Insured _____ Name of Employer_____

Patient Information consent:

I understand that Saint Camillus Urgent Care may need to use and disclose information about my health or/and medical problems for the purpose of arranging, conducting, or referring my treatment; for obtaining payment for services; and for the purposes of operating the practice. I consent to the use of my information for the purpose of treatment, payment and health care operations.

Signature:_____

Consent of Professional Services and Release of Information:

I here-by authorize and release the provider and whomever he/she delegates as his/her assistance to administer treatment, physical exam, x-ray studies, laboratory procedures, medical care or any clinical service that he/she deems necessary. I further authorize him/her to disclose all or part of my record to any person or corporation which is or may be liable under contract to the clinic or the patient or to a family member or employer of the patient for all or part of the clinic charge, including but not limited to, hospital, or medical services company, insurance company, workers compensation carriers, welfare funds, or the patients employer.

Signature:_____

Insurance Information:

I understand and agree that health and accident insurance policies are in agreement between an insurance company and myself . Furthermore, I understand that this medical office will prepare my necessary reports and forms to assist me in making collections from the insurance company and that my account, authorized to be paid directly to this medical office, will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered, are to be charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, fees for professional services rendered to me will be immediately due and payable. I understand that I am responsible for all deductibles, co-pays, co-insurance, and all non-covered services. I understand I owe 100% of my bill and agree to pay in full.

Signature_____