PEDIATRIC URGENT CARE FORT WORTH

N _____
A___ - __/__/__
C ___- __/__/__

PATIENT INFORMATION

Patient Last Name: _____ First Name: _____ MI: _____

DOB: _____/_____/_____ Patient over21 years old? ☐ YES ☐ NO Gender: ☐ Male ☐ Female

Address: _____
(Street) (Apt. #)

_____
(City) (State) (Zip)

Primary Phone: (_____) _____ Alternate Phone: (_____) _____

Email address: _____

FINANCIALLY RESPONSIBLE PARTY (PARENT/GUARDIAN/GUARANTOR)

Last Name: _____ First Name: _____ MI: _____

DOB: _____/_____/_____ Gender: ☐ Male ☐ Female SSN: _____

Relationship to patient: _____

Address: ☐ Same as Patient

_____
(Street) (Apt. #)

_____
(City) (State) (Zip)

Primary Phone: (_____) _____ Alternate Phone: (_____) _____

Email address: _____

EMERGENCY CONTACT

☐ Same as Financially Responsible Party (Parent/Guardian/Guarantor) listed above

OR

Emergency Contact Name:
_____

Relationship to Patient:
_____

Phone:
_____

PREFERRED PHARMACY

Name: _____

Location/Intersection: _____

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N _____
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INSURANCE

☐ Private/Self Pay. I do not want to file today's visit on an insurance plan.

#1 Name of Insurance Company: _____

Subscriber Name: _____ Relationship to Patient: _____

Subscriber DOB: _____/_____/_____ Gender: ☐ Male ☐ Female SSN: _____

Subscriber Address: _____
(Street) (Apt. #)

☐ Same as Patient

_____
(City) (State) (Zip)

Primary Phone: (_____) _____ Alternate Phone: (_____) _____

Employer: _____ Occupation: _____

#2 Name of Secondary Insurance Provider: _____

Subscriber Name: _____ Relationship to Patient: _____

Subscriber DOB: _____/_____/_____ Gender: ☐ Male ☐ Female SSN: _____

Subscriber Address: _____
(Street) (Apt. #)

☐ Same as Patient

_____
(City) (State) (Zip)

Primary Phone: (_____) _____ Alternate Phone: (_____) _____

Employer: _____ Occupation: _____

HOW DID YOU HEAR ABOUT US?

☐ Drive-by/ live nearby ☐ Google

☐ Facebook ☐ SOLV Online Appointment

☐ Community Event: _____ ☐ PTA event: _____

☐ Physician Recommendation: _____

☐ Referral: _____

☐Other: _____

Thank you for choosing Pediatric Urgent Care of Fort Worth!!

PEDIATRIC URGENT CARE FORT WORTH

CONSENT, ASSIGNMENT, AND RELEASE FORM

CONSENT FOR MEDICAL TREATMENT

I voluntarily present myself or my child to Pediatric Urgent Care of Fort Worth (PUCCFW) and consent to treatment of the physician on duty and whomever they may designate as their assistant, associate, treating physician and patient care staff to provide my care. Such care may include, but is not limited to, diagnostic procedures, radiological evaluations and procedures, and the administration of medications considered advisable in my diagnosis, treatment, and course of care. I acknowledge that no guarantee can be made or has been made as to the results of treatments or examinations and I understand that all medical treatments contain inherent risks. I hereby give my consent and authorization to PUCCFW, subsidiaries and practitioners to provide medical treatment to the patient. I understand that physicians and/or nurse practitioners and/or physician's assistant will explain my condition(s), foreseeable risks, and methods of treatment for my condition(s) before treatment is provided. I authorize PUCCFW, its subsidiaries and practitioners to perform any additional or different treatment that is though necessary, should, in an emergency situation, a condition be discovered which was not previously known.

GOVERNMENT COMPLIANCE (Acknowledgement that PUCCFW conforms to HIPAA & other federal regulations)

In compliance with HIPAA and the Stark Law, PUCCFW must inform you that there are other options pertaining to laboratory, diagnostic, and radiographic services. Specifically it should be noted that you (or your child) have presented to PUCCFW voluntarily for medical needs and that as part of the evaluation of your (or your child's) condition and any required treatment, the physician on duty may determine that particular laboratory, diagnostic, and radiographic tests may be needed. PUCCFW offers many of these services on-site as a convenience to our patients. If any patient would like to have their laboratory or radiographic services provided at another location we can provide you with a list of nearby locations. Additionally, PUCCFW will disclose records to educational or scientific institutions *as required by law*, authorized health care professionals in training, internal quality improvement, risk management and legal counsel when it is judged that my ongoing medical care, medical research, quality improvement, healthcare education or science will benefit; for any purpose authorized by law.

RELEASE AND USE OF PATIENT INFORMATION

I authorize the release of my medical records, information, treatment and advice, and specific health information to treating physicians on staff at PUCCFW and their staff, agents of another healthcare facility if direct transfer to another facility is required, and to my primary care physician or any referred consultants for follow up care. I understand this information may contain my personal medical history, physical, and treatments (if necessary), radiographic and laboratory results, and more specifically results in reference to alcohol/drug abuse, mental health, or infectious disease (including human immune-deficiency virus, hepatitis, or other infectious diseases). Additionally, I authorize release of my medical records, or in case of a minor, my child's medical records, to my primary care physician. This and any other subsequent authorizations to release Protected Health Information (PHI) comply with the privacy practices notice and federal HIPAA regulations.

ASSIGNMENT OF BENEFITS

In consideration of services provided, I hereby assign and transfer to PUCCFW any and all rights, which I have against insurance companies or third party payers, for payment of charges for services provided by PUCCFW to me or to one of my dependents. I authorize said payments to be applied to any unpaid balance for which I am responsible. I understand that I am responsible for and will pay the portion of my bill not covered by insurance companies or third party payers.

FINANCIAL AGREEMENT ACKNOWLEDGEMENT

I authorize my insurance benefits be paid directly to Pediatric Urgent Care Center of Fort Worth (PUCCFW) or their designated billing agency. I also authorize PUCCFW and their healthcare providers to release all information necessary to my insurance company when requested and to facilitate the payment of my claim(s). I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility. *It is our policy that any insurance co-pays and deductibles or any balance of a bill owed by those without insurance is due at the time of service.* I agree to pay the account in full upon receipt of my billing statement unless payment arrangements are made with PUCCFW. In the event of my default, or non-payment of my bill, I agree to pay all costs of collections, reasonable attorney's fees and court costs due in addition to the amount due that may be attached including an additional 35% that will be added to my balance. As the parent, guardian, or custodian of the patient, I agree to be responsible for all services rendered to minor patients. I hold PUCCFW harmless for attempts to collect regardless of parental, guardian or custodial financial responsibility. I agree to be responsible for payment regardless of any divorce, separation, or other outside agreements that may or may not be in effect at the time of service.

RECEIPT OF HIPAA PRIVACY NOTICE

I acknowledge receipt of the Notice of Privacy Rights (laminated forms attached to this document) with detailed information about how PUCCFW may use and disclose my protected health information. I understand that PUCCFW reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me. A copy of the Notice of Privacy Rights is available at any time.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE REVIEWED THE CONSENT, COMPLIANCE, RELEASE, ASSIGNMENT, FINANCIAL AND HIPAA PRIVACY NOTIFICATION. I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION.

Patient Name:_____Phone Number: _____

Signature of Patient or Parent/Guardian: _____Date/Time: _____

Signature of Witness: _____ Date/Time: _____

CAN WE LEAVE YOU VOICEMAILS?

YES	NO
I authorize PUCCFW to leave a detailed message on the answering machine or voicemail for any medical or billing purposes. _____ (Initial here)	I DO NOT authorize PUCCFW to leave a detailed message on my answering machine or voicemail. I acknowledge that by choosing this option that I, the Patient or Parent, assume full responsibility for contacting PUCCFW for the results of all testing, billing, or account balance concerns. _____ (Initial here)

CAN WE SEND YOU TEXT MESSAGES?

YES	NO
I authorize PUCCFW to send me text messages. Standard text rates may apply. _____ (Initial here)	I DO NOT authorize PUCCFW to send me text messages. _____ (Initial here)

PRIMARY CARE PROVIDER/PEDIATRICIAN:

Name/Practice: _____ □ TCU Health Center

City: _____

We will fax a summary of your/ your child's visit to your physician.
This is for safety and to ensure continuity of care. If you need a referral for a PCP, please let us know.

AUTHORIZATION TO RELEASE MEDICAL/FINANCIAL INFORMATION & OTHERS DESIGNATED TO CONSENT FOR TREATMENT

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996, in order for your physician or the staff of PUCCFW to give copies of and/or discuss your condition/exams/procedures/x-rays with members of your family or other individuals that you designate ***other than your primary care doctor or specialist***, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived. Furthermore, we must obtain your authorization to discuss financial information other individuals that you designate other than insurance companies or third party payers and their agents. In the event that you are not present with your child when they are presented for medical care at any facility of PUCCFW, you may authorize the following people to "Consent for Treatment". This consent is unlimited and without restrictions.

I authorize PUCCFW to release my, or my child's, information regarding medical care; financial status; and consent to treatment to the following people (You do not need to list your PCP/Pediatrician):

Name	Relationship To Patient	Phone Number
This person may: □ Access Medical Records	□ Access Financial Records	□ Consent for Treatment

Name	Relationship To Patient	Phone Number
This person may: □ Access Medical Records	□ Access Financial Records	□ Consent for Treatment