✚ANAHEIM URGENT CARE✚

831 S. State College Blvd., Anaheim, CA 92806
☎ 714-533-2273 (CARE) • 🖷 714-635-2273 (CARE)

Name-Last: ________________________________ First: ____________________________ M. I.: _____

Date of Birth: ____________________ **SS #:** ________________ **Gender:** ☐ Male ☐ Female

Address: ____ **DL#:** ____________ **Age:** ____

City: ________________________________ **State:** ______________ **Zip Code:** ______________

Phone Home**:** ______________________ Cell: _____________________ Work: ____________________

Employer: ____

Person to notify in case of emergency:

Name: ______________________________ **Relationship:** ____________ **Phone** Home**:** ______________

Address: ____

How did you hear about ✚ANAHEIM URGENT CARE✚?

☐ Yellow Pages ☐ Friend/Relative ☐ Employer ☐ Brochure ☐ Drive by ☐ School

☐ Internet (site) __________________________ ☐ Other: ___________________

Are you presently under the care of a physician? ☐ No ☐ Yes, Physician's Name: ________________________

Do you have any allergies or reactions to medications? ☐ None ☐ Yes, Which one? ________________________

Do you have any major medical condition? ☐ None ☐ Yes, List ____________________________________

____

What current medications are you taking?

	MEDICATION	DOSE	HOW OFTEN
1.			
2.			
3.			
4.			
5.			

I, the undersigned, hereby authorize ✚ANAHEIM URGENT CARE✚ to provide medical procedures to be performed on myself/child. By signing, I fully understand that I am responsible for any fees incurred regardless of insurance coverage or medicare coverage.

Signature: ______________________________ **Date:** ________________

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MEDICAL SERVICES AGREEMENT
(READ CAREFULLY BEFORE SIGNING)

Patient's Name: ______________________________________

1. **MEDICAL CONSENT**: I consent to any medical treatments or procedures which may be performed on an outpatient basis (including emergency treatment or services), which may include but are not limited to medications, injections, taking of medical photographs, laboratory procedures, and/or x-ray examinations provided to me under the general and special instructions of the physicians, staff, or other health care providers of Anaheim Urgent Care, Inc. assisting my care.

2. **FINANCIAL AGREEMENT: I understand that all charges are due at the time of service.** I agree to pay Anaheim Urgent Care, Inc. (herein referred to as "AUC") for all charges for healthcare services and professional services provided to me by physicians and other healthcare professionals. Acceptable forms of payment include Cash, Visa, MasterCard, Discover and Debit card. If I am a non-insured patient, I agree to pay for my visit in full at the time of service. If AUC is a participating provider with my insurance company I understand that my co-pay, coinsurance, deductible and/or any outstanding balances are due at the time of service.

   Patient or Guardian Initials ______________________

   I understand that my insurance policy is a contract between myself and my insurance company; AUC is not involved. In order for AUC to file claims and accept payments from my insurance company, I understand that I must present current insurance information at each visit and that AUC will need to verify my health insurance coverage. In the event that AUC is not able to verify my insurance eligibility and benefits before my visit, I agree to pay for my visit in full at the time of service. A refund will be issued if my insurance pays for the visit. I also understand that I am financially responsible for any services not covered by my insurance company. When my spouse or a financial guarantor signs this agreement, the spouse or the financial guarantor shall be jointly and individual liable with me. Should my account(s) be referred to an attorney or a collection agency for the collection, the undersigned shall pay the actual attorney's fees (including costs) and collections expenses incurred in addition to the other amounts due. Unpaid accounts referred to outside agencies for collection shall bear interest at the current rate per year from the date of referral.

3. **INSURANCE AUTHORIZATION AND RELEASE:** I request that payment of authorized benefits, including Medicare, and any other government sponsored program, private insurance, and any other health plans be made to AUC for any services furnished by that provider. To the extent necessary to coordinate my health care or determine liability for payment and to obtain reimbursement for services rendered, I authorize AUC to disclose portions of or all of my records, including my medical records to any person or corporation which is or may be liable for all or any portion of AUC charges, including but not limited to insurance companies, health care service plans, governmental agencies, or worker's compensation carriers. I authorize AUC to act as my agent to help me obtain any required pre-certification as well as acting as my agent to help me obtain payment from my insurance companies. I authorize my insurance companies to give AUC any information required to fulfill this function. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.

4. **RELEASE OF MEDICAL INFORMATION:** I hereby authorize AUC to release any information in my chart to any practitioner, doctor, hospital, or medical institution to whom I may be referred to assist in my care. Additionally, I authorize any request for medical information from any medical practitioner, hospital, or medical institution to assist in my care.

5. **PERSONAL VALUABLES:** AUC shall not be liable for the loss of or damage to any money, documents, jewelry, glasses, dentures, furs, or other articles of unusual value and shall not be liable for loss or damage to any personal property.

Anaheim Urgent Care, A Medical Corporation and the patient or the patient's representative, hereby enters into this agreement. The undersigned certifies that he/she has read and agree to the foregoing, received a copy thereof, and is the patient, the patient's representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

________________________	__________		________________________	__________
Signature of Patient	**DATE**	or	**Signature of Patient's Representative**	**DATE**
________________________	__________		________________________	
Medical Practice's Representative	**DATE**		**Name & Relationship of Representative to Patient**	