

Date: _____ Reason for Visit: _____

Last Name: _____ First Name: _____ MI: _____

Date of Birth (MM/DD/YYYY): _____ Female Male || Married Single

Patient SSN: _____ Military DBN (DoD Benefits Number): _____

Patient Address: _____

City: _____ State: _____ Zip Code: _____

Patient Email Address: _____

Note: For security of your records, all emails containing Protected Health Information (PHI) are sent encrypted

Grand Prairie Urgent Care and Family Medicine may leave detailed voice messages about your visit or future appointments unless you object by checking the "No" box. No | Yes, Contact Phone (Best Number): _____

Employer Name: _____ Employer Address: _____

Guarantor Information: If the guarantor (person financially responsible) is anyone other than the patient, complete this section.

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ Guarantor SS#: _____ Phone: _____

Relationship to patient: (Check one) Self Spouse Parent/Guardian Other: _____

Subscriber Information: If the insurance subscriber (person carrying the insurance) is anyone other than the patient, please complete this section:

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ Guarantor SS#: _____ Phone: _____

Relationship to patient: (Check one) Self Spouse Parent/Guardian Other: _____

Emergency Contact Name: _____ Phone Number: _____

Grand Prairie Urgent Care & Family Medicine's external survey partner may contact you to participate in a satisfactory survey about this visit. We rely on your feedback to help us improve the patient experience. May we contact you for a brief survey? Yes No

Consent for Medical Treatment

I give permission to Grand Prairie Urgent Care and Family Medicine to perform the following services that the physicians and other non-physician providers and assistants may deem to be necessary: (a) medical, surgical, and diagnostic (e.g.: including, but not limited to, x-rays, blood draws, and laboratory tests) processes, treatments, and procedures; (b) administration of injections, medications, and immunizations (with immunizations to occur after my receipt of any applicable vaccine information statements ("VIS" or "VISs")); and (c) completion of medically appropriate tests for communicable and other diseases.

Signature: _____ Date: _____

Consent for Wellness and Preventative Health Screening

I give permission to Grand Prairie Urgent Care and Family Medicine to perform a wellness and/or preventative health screening. I understand that I am solely responsible for following up with my personal physician or other healthcare provider about the results of my screening. In performing the wellness screening, Grand Prairie Urgent Care and Family Medicine does not assume any responsibility for ongoing treatment or management of care.

Signature: _____ Date: _____

Today's Payment

Payment made today will be paid by:

- Self Patient Pay – I will be paying today using:
- Cash Check VISA MasterCard Discover Debit Card American Express
- Insurance – I will present my insurance card and an approved form of ID.

How will you be paying today's bill?

Financial Policy

Unless you are here for employer paid services, you will be responsible for either full payment or payment as indicated by your insurance plan. If Grand Prairie Urgent Care and Family Medicine has a contract with your insurance company, we will file today's charges with that insurance company. You will be responsible for your co-payment and/or deductible, and the cost of any services not covered by insurance. You may receive a bill from Grand Prairie Urgent Care and Family Medicine for any unpaid balance.

If you have insurance...

I understand that I am financially responsible for all charges not covered by my insurance. **Initials** _____

If you don't have insurance.....

If you do not have insurance coverage or Grand Prairie Urgent Care and Family Medicine does not have a direct contract with your insurance company, you will be required to pay in full for your visit today. You can expect to pay an initial payment for medical care/treatment based on posted pricing in the center. This will be collected at check-in.

If your treatment requires more complex evaluations, lab tests, vaccines, medications, X-rays, or supplies, Will be charged for those in addition to the appropriate office visit fee. These fees will be collected after service and treatment have been provided.

I do not have insurance and I acknowledge that I am responsible for all costs. **Initials** _____

Release of Medical Records, Assignment of Benefits, Financial Responsibility

Grand Prairie Urgent Care and Family Medicine will submit claims to my insurance carrier as well as medical records needed to evaluate the claims for payment. I further assign payment of benefits, otherwise payable to me, to be made payable to Grand Prairie Urgent Care and Family Medicine.

I understand that I am financially responsible for all charges not covered by my insurance.

Print Name: _____ Signature: _____ Date: _____

Primary Care Physician

Name: _____ City: _____

State: _____ Telephone Number: _____

Notice of Privacy Practices

Your name and signature below indicate that you have been made aware of Grand Prairie Urgent Care and Family Medicine's Notice of Privacy Practices (NOPP) on the date indicated. You understand that the NOPP is posted in the center and a copy will be provided to you if you request it. If this is your first date of service with Grand Prairie Urgent Care and Family Medicine, please indicate this to the front desk receptionist and he/she will provide you a copy of the NOPP. If you have any questions regarding the information in Grand Prairie Urgent Care and Family Medicine's Notice of Privacy Practices, contact Grand Prairie Urgent Care and Family Medicine at 972-755-1785.

Print Name: _____ Date Notice Received: _____ Signature: _____