

*****REASON FOR TODAY'S VISIT

IF ACCIDENT: _____ DATE _____ AUTO _____ WORK _____ OTHER _____

EXPLAIN _____

PATIENT NAME: (LAST _____ (FIRST) _____ (M) _____ HOME PHONE (_____) _____

ADDRESS: _____ APT _____ CELL PHONE (_____) _____

CITY _____ STATE _____ ZIP CODE _____ E-MAIL _____

MAILING ADDRESS (IF DIFFERENT FROM ABOVE) _____

CITY _____ STATE _____ ZIP CODE _____ FIRST VISIT TO CLINIC? _____ YES _____ NO

DATE OF BIRTH _____ / _____ / _____ AGE _____ GENDER: MALE FEMALE SOCIAL SECURITY # _____ - _____ - _____

RACE _____ ETHNICITY (HISPANIC OR NOT HISPANIC) _____ LANGUAGE _____

EMPLOYED: _____ FULL TIME _____ PART TIME _____ FULL TIME STUDENT _____ PART TIME STUDENT _____ SINGLE _____ MARRIED _____ WIDOW(ER) _____ OTHER

EMPLOYER _____ OCCUPATION _____ WORK PHONE (_____) _____

PRIMARY CARE PHYSICIAN _____ TELEPHONE _____

RESPONSIBLE PARTY / RELATIONSHIP FATHER MOTHER LEGAL GUARDIAN OTHER _____

NAME _____ DATE OF BIRTH _____ SS# _____

PHONE _____ EMPLOYER NAME _____

ADDRESS (IF DIFFERENT FROM ABOVE) _____

PRIMARY INSURANCE _____ SUBSCRIBER SS# _____

SUBSCRIBER (IF DIFFERENT FROM PATIENT) _____ DATE OF BIRTH _____ RELATION _____

SUBSCRIBER ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

SECONDARY INSURANCE _____ SUBSCRIBER _____

HIPPA AUTHORIZATION AND AGREEMENT FOR MEDICAL TREATMENT

CONSENT OF TREATMENT: I hereby grant my authorization and consent to such treatment and procedures, and certify that no guarantee or assurance has been made as to the results obtained.

COMPLICATIONS: I understand that it is my responsibility to return to the South Tampa Immediate Care Clinic or report any change in my condition to the Clinic's doctor.

AGGREEMENT TO PAY SERVICES: For and in consideration of the care and treatment provided to the patient, I promise to pay South Tampa Immediate Care Clinic all charges for services rendered to or on behalf of the patient. Authorization from my insurance company does not always guarantee payment. The undersigned and/or patient shall remain responsible for all charges. Payment to South Tampa Immediate Care Clinic is due upon receipt of statement.

PRIVACY NOTICE: I acknowledge that I have received South Tampa Immediate Care Clinic Privacy Notice., PLEASE INITIAL _____

I AUTHORIZE SOUTH TAMPA IMMEDIATE CARE TO SUBMIT A CLAIM TO THE INSURANCE COMPANY ON MY BEHALF. PLEASE INITIAL _____

I AUTHORIZE SOUTH TAMPA IMMEDIATE CARE TO DOWNLOAD MY MEDICATION HISTORY FROM A PHARMACY CLEARINGHOUSE. PLEASE INITIAL _____

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE ABOVE AND IS THE PATIENT, GUARANTOR OR THE PATIENT'S REPRESENTATIVE DULY AUTHORIZED TO EXECUTE THIS AGREEMENT AND ACCEPT ITS TERMS.

DATE _____ X _____ SIGNATURE OF PATIENT / REPRESENTATIVE _____

PRINT REPRESENTATIVE NAME _____ REPRESENTATIVE'S RELATIONSHIP TO PATIENT _____

Please list the family members or other person, if any, who we may inform about your general medical condition and your diagnosis (including treatment, payment and health condition)

IN CASE OF EMERGENCY: Please list the family members or significant others, if any whom we may inform about your medical condition

NAME _____ PHONE _____