



# PATIENT INFORMATION

- Tuscaloosa - 5005 Oscar Baxter Drive
- Northport - 3909 McFarland Boulevard
- Demopolis - 705 Highway 80 West
- Hoover - 1575 Montgomery Highway
- Fayette - 122 17th Court Northeast

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Age: \_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_

Are you a home health patient? **Yes or No** If yes, name of agency \_\_\_\_\_

Are you a nursing home patient? **Yes or No** If yes, name of facility \_\_\_\_\_

Patient Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Address: \_\_\_\_\_

Home Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Email address: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Person to notify in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

**Policy Holder Social Security Number:** \_\_\_\_\_ **Policy Holder Birthdate:** \_\_\_\_\_

**If patient is under the age of 19; we must have the following information:**

Guardian's Name: \_\_\_\_\_ Social Security: \_\_\_\_\_

Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Number: \_\_\_\_\_ Secondary Number: \_\_\_\_\_

**CONSENT FOR TREATMENT:** I consent to necessary treatment, including drugs, medicine, x-rays, lab tests and/or other studies that may be used by the medical staff.

**AUTHORIZATION FOR RELEASE OF INFORMATION:** I understand that my medical information may be given to the insurance whom I have coverage, agencies which may be assisting with payment for my care, billing agencies, agencies responsible for reviewing payments and/or quality of care, and other governmental agencies. I give permission for the release of this information.

**ASSIGNMENT OF BENEFITS:** I hereby authorize payment directly to MedCenter of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the MedCenter charges for these services. I understand that I am financially responsible to MedCenter for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverages are subject to coordination of benefits.

**GUARANTEE OF ACCOUNT:** For services furnished by MedCenter I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all costs of collection, including attorney's fee.

**PERMISSION TO RELEASE INFORMATION:**

If you anticipate the need for anyone else to have access to protected health information about you, please complete the information below. I (we), the undersigned patient and/or responsible party hereby authorize MedCenter Urgent Care, its physicians, agents, employees or representatives to discuss to patient information about me including but not limited to past and current medical information, billing information, appointment scheduling, prescriptions, etc release any or all to the person or persons indicated below:

<b>Spouse</b>	<b>Name</b>
<b>Parents</b>	<b>Name(s)</b>
<b>Children</b>	<b>Name(s)</b>
<b>Other</b>	<b>Name(s)</b>

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

All patients age 14 and above **MUST** sign their own paperwork.