PATIENT INFORMATION

MedCenter
Urgent Care • Family Medicine

- ☐ 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 fo 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 herby authorize MedCenter Urgent Care, its physicians, agents, employees or representatives to discuss to patient information about me including but not limited to past and currect medical information, billing information, appointment scheduling, prescriptions, etc release any or all to the person or persons indicated below:

Spouse	**Name**
Parents	**Name(s)**
Children	**Name(s)**
Other	**Name(s)**

PATIENT SIGNATURE: _____ **DATE:** _____
All patients age 14 and above MUST sign their own paperwork.