MedPoint Urgent Care Center, LLC

2412 Jacaman Road Suite 105
Laredo, TX 78041
(956) 615-0266 P (956) 615-0140 F

Demographics

Last Name: _____First Name: _____

Date of Birth: _____ Age: _____ Soc. Sec. # _____

Sex: [ ] Male [ ] Female Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Separated [ ] Divorced

Address: _____

City: _____ State: _____ Zip code: _____

Phone Number: Home: _____Cellular: _____ Work: _____

E-mail Address: _____

In case of an emergency who should be notified? _____
Relationship to Patient: _____
Phone Number: _____

Primary Insurance Coverage

Primary Insurance Coverage: _____ Primary Soc. Sec. # _____

Name of Subscriber: _____ Date of Birth: _____

Patient's relationship to subscriber: [ ] Self [ ] Spouse [ ] Son [ ] Daughter

Policy ID/Member Number: _____ Group Number: _____

Secondary Insurance Coverage

Secondary Insurance Coverage: _____

Name of Subscriber: _____ Date of Birth: _____

Policy ID/Member Number: _____ Group Number: _____

I hereby authorize MedPoint Urgent Care Center, LLC to release information acquired during the course of my examination and treatment to the Health Care Financing Administration and its agents, or any other third-party carrier as necessary to secure payment of any benefits due. I hereby assign payment of said benefits to include Medicare benefits directly to MedPoint Urgent Care Center, LLC. I understand that I am responsible for all charges regardless of insurance status as well as any associated cost for collection should such action become necessary. I agree that this authorization shall be valid until writing or replaced by one of a later date. A photocopy of this assignment shall be considered as valid as the original. I have read the above and fully understood the terms there of.

Signature: _____ **Date:** _____

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I fully understand the terms of this consent.

Please circle one: **Accept Decline**

_____ _____

Patient Signature **Date**

_____ _____

Signature of Authorized Person if other than Patient **Relationship to Patient**

Consent for Medical Treatment of a Minor Child
in absence of Parent/ Legal Guardian

I _____ parent of _____ give consent to the following persons to act on my behalf to consent for MedPoint Urgent Care Center, LLC to provide medical treatment to my child:

Name of Person: 1) _____ Relationship: _____

2) _____ Relationship: _____

3) _____ Relationship: _____

further release MedPoint Urgent Care Center, LLC of any liability that may arise during the absence.

This consent for Medical, Psychological and Surgical Treatment is valid for a period of one (1) year from date of the signature.

_____ _____

Signature of Authorized Person **Date**

FOR OFFICE USE ONLY

[ ] Consent received by: _____

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on _____.

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Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of MedPoint Urgent Care Center, LLC Notice of Privacy Policies, detailing how my information may be used and disclosed may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information.

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____ Date: _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ Witnessed by: _____

Internal Use Only:

If Patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and signed below.

Presented on (date and time): _____

By (name and title): _____

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Coverage of Medical Expenses

When signing this document, I or the person signing on my behalf, are in charge of covering any expenses not paid by my insurance. The denial of payment could be due to deductible, copays, or other aspect that needs to be arranged with the insurance.

Name of patient or person responsible: _____

Signature of patient or person responsible: _____

Date: _____