Independence Urgent Care
7192 North Main Street
Clarkston, MI 48346

PATIENT INFORMATION

NAME (LAST, FIRST, MIDDLE INITIAL) BIRTHDATE AGE SEX M F SOCIAL SECURITY NUMBER MARITAL STATUS S M W D

ADDRESS CITY STATE ZIP PHONE

( )

EMPLOYER (PATIENT OR PARENT) DAYTIME PHONE PRIMARY PHYSICIAN

RELATIVE TO NOTIFY IN CASE OF EMERGENCY RELATIONSHIP PHONE

( )

INSURANCE INFORMATION

NAME OF INSURANCE HOLDER BIRTHDATE RELATIONSHIP TO PATIENT SOCIAL SECURITY NUMBER

ADDRESS CITY STATE ZIP PHONE

( )

EMPLOYER NAME AND ADDRESS CITY STATE ZIP PHONE

( )

NAME OF INSURANCE

DO YOU HAVE ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING

NAME OF INSURANCE HOLDER BIRTHDATE RELATIONSHIP TO PATIENT SOCIAL SECURITY NUMBER

ADDRESS CITY STATE ZIP PHONE

( )

EMPLOYER NAME AND ADDRESS CITY STATE ZIP PHONE

( )

NAME OF INSURANCE

HOW DID YOU LEARN ABOUT THE FACILITY?

AUTHORIZATION FOR TREATMENT AND BILLING: I consent to any medical, diagnostic, therapeutic, or minor surgical procedure rendered to the patient under the supervision of the physicians. I hereby recognize that the practice of medicine and surgery is not an exact science and I acknowledge that no one has made any representation, guarantee, or warranty to me regarding the results to be achieved by any treatments or examinations that I (or the patient) will receive as a result of services. I authorize release of my patient records, including alcohol and drug abuse records protected under the regulations in Code 42 of Federal Regulations, Part 2, if any; psychological services records, if any; social services records, if any; including communications made by me to a social worker or psychologist; records of Human Immunodeficiency Virus (HIV) testing including results, if any; records of treatment for Acquired Immune Deficiency Syndrome (AIDS), if any, and records of a communicable disease, if any; to my insurance company(s) for the purpose of payment of bill and to my health care provider for continuity of care. **I authorize and request my insurance company to pay directly to the provider the amount due for medical care. IN ADDITION, I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY AMOUNTS THAT ARE NOT COVERED, AUTHORIZED OR PAID BY MY INSURNACE COMPANY. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered.** I understand that if any employee, physician or agent of SJMH-O sustains a percutaneous (through the skin), mucous membrane (through the mouth or eye), or open wound exposure to my blood or other bodily fluids, I may be tested for Human Immunodeficiency Virus (HIV) which causes Acquired Immune Deficiency Syndrome (AIDS). **I HEREBY CERTIFY THT THE CONTENTS OF THIS FORM ARE UNDERSTOOD BY ME. PARAGRAPHS OR LINES THAT I CHOOSE NOT TO PERTAIN TO ME, IF ANY, WERE STRICKEN BEFORE I SIGNED:**

SIGNATURE DATE (VALID FOR ONE YEAR) WITNESS

AUTHORIZATION TO TREAT

I AUTHORIZE INDEPENDENCE URGENT CARE TO PROVIDE ME OR MY MINOR CHILD / WARD LISTED ABOVE WITH ANY REQUIRED MEDICAL, DIAGNOSTIC, THERAPEUTIC AND / OR MINOR SURGICAL PROCEDURES / TREATMENTS AS MAY IN THEIR PROFESSIONAL JUDGEMENT BE NECESSARY / BENEFICIAL FOR MY HEALTH OR THE HEALTH OF MY MINOR CHILD / WARD IN MY ABSENCE.

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AUTHORIZED REPRESENTATIVE NAME	AUTHORIZED REPRESENTATIVE SIGNATURE	RELATIONSHIP TO PATIENT