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# Acute Kids Urgent Care

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Frisco Plano McKinney Flower Mound Allen

*Effective 1-1-09, Acute Kids Urgent Care has a new self pay policy for families of children not currently covered by insurance. Please request a copy of the policy from any staff member for your review.*

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Time: \_\_\_\_\_

Street

\_\_\_\_\_ Date of Birth: \_\_\_\_\_

City

State

Zip

Patient's Age: \_\_\_\_\_ days/weeks/months/years Patient's Gender: Male / Female

Home Phone Number: \_\_\_\_\_ Other Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_ Private Physician: \_\_\_\_\_

Guardian's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Subscriber Date of Birth: \_\_\_\_\_ Subscriber SSN: \_\_\_\_\_

m/d/y

**The insurance information requested above is frequently not found on your insurance card.**

**Privacy Practices Policy:** Signing below also indicates that you have been given a chance to review a copy of the Acute Kids Urgent Care Privacy Practices Policy and all of your questions regarding this policy have been answered. A copy of this policy is available on request.

**Assignment of Benefits:** I hereby authorize the release of medical information to my insurance company(s), and assign benefits otherwise payable to Acute Kids Urgent Care. A copy of this is as valid as the original. I understand that payment is due at the time of service, and I am fully responsible for my charges. Revocation: I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization for the purposes stated above. I further release my physician from any liability arising from the release of information to the individual(s) agency designated herein.

\_\_\_\_\_  
Patient / Responsible party

\_\_\_\_\_  
Date m/d/y