IMC IMMEDIATE MEDICAL CARE, P.A.
From Urgent Care to Family Care For Adults and Children

Patient Information

Name: Last_____First_____Age_____DOB____/____/_____

Sex___M___F SS#_____/_____/_____Marital Status_____Occupation_____

Work Phone (____)_____-_____ Home Phone (____)_____-_____ _Cell Phone (____)_____-_____

Address_____

Email Address_____Employer_____

Emergency Contact_____Phone (____)_____-_____Relationship_____

If the Patient is under 18, please provide, Parent/Guardian's Name:_____

Parent/ Guardian's Address_____

Reason for visit: Routine_____ Illness_____ Physical_____ _Auto Accident_____ Work Injury_____

How will you be paying for today's visit? Cash_____ Debit Card_____ Visa / Master Card_____

Insurance Name_____Insurance ID_____Co-pay_____Deductible_____

Assignment of Benefits

The undersigned, whether signing as a patient, representative or guarantor, hereby authorizes direct payment of any insurance benefits otherwise payable to or on behalf of the patient to Immediate Medical care, P.A. I hereby assign to Immediate Medical care, P.A., and all medical Benefits otherwise payable to me by virtue of my visit to Immediate Medical Care, P.A. I hereby direct the insurer to pay such benefits directly to Immediate Medical Care, P.A., in consideration of the professional services rendered to me, or my insured dependent or any insured person designated in my policy. I understand I will be responsible for payment of Services not covered and/ or denied by health insurance.

Signature:_____

Notice of Health Information Privacy

I have been presented with and Immediate Medical Care, P.A.'s notice of privacy. Our notice provides information detailing how your health information may be used and disclosed as permitted under federal and state law. I understand that contents of this notice, I understand I may request restrictions concerning the use of my personal health information and that we will notify you if we are unable to agree to a restricted request. Further, I permit a copy of this authorization to be used in place of the original. I consent to treatment necessary for the care of the above named patient. I authorize release of all medical records to referring physician, my insurance carrier and medical providers involved in my care. I acknowledge full financial responsibility for the services rendered by Immediate Medical Care, P.A. I understand payment is due at the time of service. I have read, fully understand and agree to the above.

Signature:_____ Date:_____

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

Relationship:_____ Witnessed by:_____

PLEASE PRESENT INSURANCE CARD (IF APPLICABLE) AND PHOTO I.D. TO THE OFFICE MANAGER TO BE COPIED.

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