

Taylor Medical Center

URGENT CARE

New Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____ City, State & Zip : _____

Patient Social Security Number : _____ Sex: **Male** or **Female**

Phone : Home: _____ Work: _____ Cell: _____

What is the best way for us to leave you a message? **Home** or **Work** or **Cell**

Spouse: _____ Spouse Date of Birth: _____

Insurance Information:

Insurance Plan Name: _____

Policy Holder Relationship to Patient: **Self** or **Spouse** or **Parent** or **Other** _____

Policy Holder's Name: _____ Date of Birth: _____

Employer: _____ Phone: _____

I give Taylor Medical Center permission to discuss my medical care with the following person(s):

1: _____ 2: _____

3: _____ 4: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby authorize payment directly to the physician/provider of the surgical and/or medical benefits if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the physician/provider to release any information acquired in the course of my treatment deemed necessary to process insurance claims.

Signature of Patient/ Responsible Party: _____ Date: _____

Taylor Medical Center

URGENT CARE

Authorization for Treatment

Medical care is a patient care service provided in response to a wide range of medical care needs of all ages regardless of gender, color, race, creed, national origin, or disability, five days a week.

The purpose of medical care is:

- To treat disease, injury, and disability by examination, testing, and use of procedures, in the aid of diagnosis or treatment.
- To obtain information needed in diagnosing and examining patients.
- To prevent or minimize residual physical and mental disability.
- To aid patients in achieving their maximum potential within their capabilities.
- To accelerate convalescence and reduce the length of the functional recovery.

All procedures will be thoroughly explained to you before they are performed. You are not expected to experience any increase in your current level of pain or discomfort. You should stop any procedure before you experience any increase in your current level of pain or discomfort.

You are expected to cooperate fully with the examination and stop any test or procedure before experiencing any increase in your current level of pain or discomfort.

There are certain inherent risks with medical care. You will be able to stop any procedure if you feel any discomfort. The attending physician will take every precaution to ensure you are protected from any potentially hazardous situation. You will never be forced to perform any procedure that you do not wish to perform. For your personal safety, do not use any equipment without a staff member present.

Based on this information, I agree to cooperate fully and to participate in all medical care procedures and to comply with the plan of care as it is established.

I acknowledge that I have read and received copies of the Authorization for Treatment and the Patient's Rights and Responsibilities.

I have received written information regarding my rights under HIPPA and this facilities notice of privacy practice. _____ Accept _____ Decline

Patient Name (Please Print)

Social Security Number

Patient Signature

Date

Witness Signature

Date

Taylor Medical Center

URGENT CARE

Attention New Patients

Taylor Medical Center treats most medical ailments, but does not accept patients for pain management purposes.

If you require prescriptions of pain medicines, such as Vicodin, Lortab, Oxycontin, Percocet, Robaxim, Xanax, Valium, or other controlled drugs, we will be happy to refer you to a pain management specialist. We prescribe these and similar medicines for acute purposes only. We do not prescribe them for chronic problems.

Our providers will be happy to treat your other medical problems and welcome you to our clinic.

Respectfully,

Taylor Medical Center

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____