Minor Emergency Clinic
500 E. Caesar Ave.
Kingsville, TX 78363

PERSONAL INFORMATION

Patient Name:____ Today's Date: ____________

Date of Birth:____________________ Age:___________ Social Security #: ______________________

Gender: Male/Female Marital Status: Single/Married/Divorced/Separated/Widowed

Address: _______________________________City______________State:________Zip: ________

Employer:__________________________________ Occupation: ___________________________

Home Phone: _____________________________________Cell Phone: ______________________

Work Phone:____________________________ Email: ___________________________________

In the event of an emergency, whom should we contact: _____________________________________

Relationship:________________________Home Phone #: _____________Cell Phone #:___________

Address if not living with you:____

INSURED/SUBSCRIBER

Name:____Relationship: _________________

Date of Birth:_________________S.S.#:__________________________ Phone #: _______________

Address:____________________________ City____________State________Zip: ______________

Employer:____ Work Phone #: _________________

Insurance Company Name: ____

I.D. #:___________________________________ Group #: ________________________________

ASSIGNMENT OF BENEFITS AND RELEASE OF PATIENT HEALTHCARE INFORMATION

I hereby authorize StatCare Minor Emergency Clinic to release and disclose protected health information (PHI) about me or my minor dependent, in accordance to the policy of the clinic and Texas Law, to facilitate reimbursement by a health benefit plan or third party payor, including but not limited to, my insurance carrier, Medicare, and any other payer or agency.

I also hereby authorize payment of insurance benefits under the terms of my policy directly to StatCare Minor Emergency Clinic for services rendered. I am financially responsible and will pay for charges not covered by my insurance plan.

FINANCIAL AGREEMENT AND STATEMENT OF RESPONSIBILITY

For and in consideration of services rendered or to be rendered by StatCare Minor Emergency Clinic, I agree to pay said clinic for all services and charges. I understand that I am responsible for any health insurance deductibles, coinsurance, and non-covered charges. Payment in full is due at time services are rendered. I give this office the right to seek the services of a bill collecting agency in efforts to collect fees that my insurance company has not paid and that I have not paid for services rendered.

Initials of Patient/Guarantor **X** ___________

CONSENT TO MEDICAL TREATMENT BY PHYSICIAN

I, or legal guardian acting on behalf of the patient, do hereby consent to receiving general medical services, which may include routine diagnostic procedures and such medical treatment as the physician, his/her assistants or his/her designees consider to be necessary in his/her judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to results of treatments or examination at StatCare Minor Emergency Clinic.

Initials of Patient/Guarantor **X** _____________

CONSENT TO MEDICAL TREATMENT BY A PHYSICIAN ASSISTANT/NURSE PRACTITIONER

I, or legal guardian acting on behalf of the patient, do hereby consent to receiving general medical services, which may include routine diagnostic procedures and such medical treatment from a physician assistant (PA) or a nurse practitioner (NP). I fully understand that a PA or an NP <u>IS NOT A PHYSICIAN</u>. I further acknowledge that the general medical services provided to me by a PA or NP are the responsibility of the collaborating physician of the PA and/or the NP both professionally and legally, for acts of such allied health personnel rendered to me or my dependent.

Initials of Patient/Guarantor **X** ___________

RELEASE OF PATIENT HEALTHCARE INFORMATION

I hereby authorize StatCare Minor Emergency Clinic to release patient healthcare information, in accordance with the policy of the clinic, as is necessary to healthcare providers to facilitate reimbursement by a health benefit plan or personnel of another healthcare entity for the sole purpose of providing current continuum of care including, but not limited to fax, mail, or electronic submission.

Initials of Patient/Guarantor **X** ___________

Do you have an advanced directive (living will)? _______________ YES _______________NO

If yes, please bring a copy into our office for our files. If no, and you would like information, please speak with the healthcare provider.

**THE ABOVE AUTHORIZTIONS ARE VALID UNLESS YOU SPECIFY OTHERWISE
OR REVOKE THEM IN WRITING**

DISCLAIMER

I agree to hold StatCare Minor Emergency Clinic, health care providers, Physicians, and staff harmless for any and all accidents occurring at 500 E. Caesar Ave. Kingsville, TX 78363. Patients, parents, and/or guardians are responsible for all damage to property.

Initials of Patient/Guarantor **X** ___________

X____________________________________/_________________________________ Date:_____________

(Patient/Guarantor Signature) (Printed Name)