

PATIENT INTAKE FORM



Today's Date: _____

PERSONAL INFORMATION

Patient's Full Legal Name: _____ Age: _____

Date of Birth: _____ Social Security #: _____ Gender: Male / Female

Address: _____ City _____ State: _____ Zip: _____

Marital Status: Single/Married/Divorced/Separated/Widowed Cell Phone #: (____) _____

Alternate Phone #: (____) _____ Email Address: _____

Employer: _____

Occupation: _____ Work Phone: (____) _____

INSURED/SUBSCRIBER

Name: _____ Relationship: _____

Date of Birth: _____ S.S.#: _____ Phone #: (____) _____

Address: _____ City _____ State _____ Zip: _____

Employer: _____ Work Phone #: (____) _____

Insurance Company Name: _____

I.D. #: _____ Group #: _____

EMERGENCY CONTACT

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

Relationship: _____ Phone #: _____ Alternate Phone #: _____

Address if not living with you: _____

DISCLOSURE OF HEALTH CARE INFORMATION TO FRIENDS AND FAMILY MEMBERS

Do you authorize StatCare Urgent Care to disclose your Protected Health Information (PHI), including medical condition, test results, diagnosis, and treatment plans, to a family member or other designated individual? Your health information will remain confidential and will not be shared with family members, friends, employers, or your spouse unless you provide explicit authorization.

NO – I do NOT authorize disclosure of my PHI to any individual.

YES –I authorize StatCare Urgent Care to disclose information related to my condition, diagnosis, treatment, and results to the individual(s) listed below. This **does not include** psychotherapy notes, HIV/AIDS information, substance use disorder records (42 CFR Part 2), or other specially protected information unless separately authorized by law.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I understand this authorization is voluntary. I may revoke this authorization at any time in writing

X _____ / _____ Date: _____
Patient Signature Printed Name

A PARENT/LEGAL GUARDIAN'S SIGNATURE IS REQUIRED IF THE PATIENT IS BELOW 18 YEARS OF AGE

Parent/Legal Guardian's full legal name (print) _____

Parent/Legal Guardian's signature _____ Date: _____

ADVANCE DIRECTIVE/LIVING WILL

Do you have an advance directive or living will? Yes (Please provide a copy for our files) No If you would like information, please speak with the healthcare provider.



ASSIGNMENT OF BENEFITS AND AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I authorize StatCare Urgent Care to use and disclose my PHI regarding myself or my minor dependent as permitted under the Health Insurance Portability and Accountability Act (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code Chapter 181) for purposes of treatment, payment, and healthcare operations.

Such disclosure may include submission of claims, insurance verification, coordination of care with other healthcare providers, quality review activities, and legally permitted electronic transmission. Any disclosure will be limited to the minimum necessary information required by federal and Texas law.

I authorize direct payment of insurance benefits to StatCare Urgent Care for services rendered. I understand that I am financially responsible for deductibles, coinsurance, and any charges not covered by insurance.

This authorization remains valid unless revoked in writing and does not apply retroactively to actions already taken.

X _____ / _____ Date: _____
Patient/Guarantor Signature Printed Name

MEDICARE BENEFICIARY AUTHORIZATION (If Applicable)

I certify that the information provided for Medicare payment is correct. I authorize release of any information necessary to process this claim and request that payment of authorized Medicare benefits be made directly to StatCare Urgent Care.

X _____ / _____ Date: _____
Patient/Guarantor Signature Printed Name

FINANCIAL AGREEMENT AND STATEMENT OF RESPONSIBILITY

I agree to pay for services rendered by StatCare Urgent Care. I understand I am responsible for deductibles, coinsurance, non-covered services, and balances not paid by insurance. Payment is due at the time of service unless other arrangements are made. Unpaid balances may be referred to collections as permitted by Texas law. Reasonable collection costs and attorney fees may be added as permitted by law.

Initials of Patient/Guarantor X _____

CONSENT TO MEDICAL EVALUATION AND TREATMENT

I, or legal guardian acting on behalf of the patient, voluntarily consent to medical evaluation, diagnostic procedures, and treatment provided by physicians, physician assistants, nurse practitioners, and other clinical staff affiliated with StatCare Urgent Care.

I understand:

- Nurse Practitioners (NPs) and Physician Assistants (PAs) are licensed providers who practice in collaboration with a Texas-licensed physician.
- I have the right to ask questions and to refuse treatment.
- The practice of medicine is not an exact science, and no guarantees have been made regarding outcomes

Initials of Patient/Guardian X _____

PERSONAL PROPERTY NOTICE

StatCare Urgent Care maintains a safe environment. Patients and visitors are responsible for their personal belongings. The clinic is not responsible for loss or theft of unattended items except as required by law.

Initials of Patient/Guardian X _____

NO VIDEO, AUDIO, OR PHOTOGRAPHY POLICY

To protect the privacy of patients and staff, unauthorized recording is prohibited within StatCare Urgent Care facilities. Video recording, audio recording, photography, and/or live streaming or social media broadcasting are not permitted without prior written authorization from clinic administration. This includes recording clinical encounters, staff, or other patients. Unauthorized recording may result in termination of the visit, refusal of non-emergent services, removal from the premises, and/or notification of law enforcement when appropriate. This policy does not limit a patient's right to access medical records or legally protected activities.

Initials of Patient/Guardian X _____

I certify that the information provided is true and accurate to the best of my knowledge. I acknowledge that I have read and I understand the above policies and consents.

X _____ / _____ Date: _____
Patient/Guardian Signature Printed Name

