☐**Kingsville:** 500 E. Caesar Ave. Kingsville, TX 78363
(O) 361.516.0800 (F) 361.516.0855

☐**Staples:** 6646 S. Staples Suite 122 Corpus Christi, TX 78413
(O) 361.334.2023 (F) 361.334.2025

☐**SPID:** 3817 S. Padre Island Dr. Corpus Christi, TX 78415
(O) 361.334.2035 (F) 361.334.2038

☐**Calallen:** 4042 River Hill Dr. Corpus Christi, TX 78410
(O) 361.933.5187 (F) 361.933.5189

☐**Rockport:** 2102 FM 2165 Rockport, TX 78382
(O) 361.556.5770 (F) 361.556.5771

Stat Care
Urgent Care Clinic

PERSONAL INFORMATION

Patient Name:_____ Today's Date: _____

Date of Birth:_____ Age:_____ Social Security #: _____

Address: _____City_____State:_____Zip: _____

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

Employer:_____ Occupation: _____

Cell Phone: (____)_____ Home Phone: (_____)_____

Work Phone: (____)_____ Email: _____

INSURED/SUBSCRIBER

Name:_____Relationship: _____

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

Address:_____ City_____State_____Zip: _____

Employer:_____ Work Phone #: (_____)_____

Insurance Company Name: _____

I.D. #:_____ Group #: _____

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

Relationship:_____Home Phone #: _____Cell Phone #:_____

Address if not living with you:_____

DISCLOSURE OF HEALTH CARE INFORMATION TO FRIENDS AND FAMILY MEMBERS

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION?

____NO   or   ____YES. If YES, please identify specific persons or entities you authorize us to share your health information with. We will not discuss your health information with family members, friends, employer, or spouse unless you authorize us to.

Name _____ Relation to You: _____Primary Phone:_____
Name _____ Relation to You: _____Primary Phone _____

I am a patient (or legal representative or guardian thereof) of StatCare Urgent Care clinic, and I give permission for my (or the minor patient I am representing) Protected Health Information to be disclosed for the purposes of communicating results, findings, and care decisions to the family members and others as listed above.

Patient/Patient Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Patient's full legal name (print) _____
Patient's signature (If 18 years of age or older)_____Date _____

Parent/legal guardian's signature required if the patient is a minor (Below 18 years of age)
Parent/Legal Guardian's full legal name (print) _____
Parent/Legal Guardian's signature _____Date _____

ASSIGNMENT OF BENEFITS AND RELEASE OF PATIENT HEALTHCARE INFORMATION

I hereby authorize StatCare Urgent Care 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 Urgent Care Clinic for services rendered. I am financially responsible and will pay for charges not covered by my insurance plan.

Initials of Patient/Guarantor **X** _____

FINANCIAL AGREEMENT AND STATEMENT OF RESPONSIBILITY

For and in consideration of services rendered or to be rendered by StatCare Urgent Care 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 Urgent Care 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 IS NOT A PHYSICIAN, but both do work in collaboration with a Texas licensed physician.

Initials of Patient/Guarantor **X** _____

RELEASE OF PATIENT HEALTHCARE INFORMATION

I hereby authorize StatCare Urgent Care 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 Urgent care clinic, health care providers, Physicians, and staff harmless for any and all non-medical related accidents occurring at any of the clinic locations. Patients, parents, and/or guardians are responsible for all damages to property.

Initials of Patient/Guarantor **X** _____

X_____/_____ Date:_____
   (Patient/Guarantor Signature)   (Printed Name)