AFFORDACARE
URGENT CARE CLINIC

AN INSURANCE CARD MUST BE PRESENTED AT TIME OF CHECK IN

PATIENT NAME: _____ **SEX:** ☐ **M** ☐ **F** **DATE OF BIRTH:**_____ **MARITAL STATUS:** ☐ **M** ☐ **S** ☐ **W** ☐ **D**
SSN:_____ **ADDRESS:**_____ **CITY/STATE:**_____
ZIP CODE:_____ **PHONE: (____)**_____ **CELL: (____)**_____
EMAIL :_____ *Will NOT be used to transmit personal health information*

GUARANTOR INFORMATION: **NAME:**_____ **DATE OF BIRTH:**_____
RELATIONSHIP: ☐ **SELF** ☐ **SPOUSE** ☐ **PARENT** ☐ **OTHER -** _____ **SSN:**_____
ADDRESS:_____ **CITY/STATE:**_____
PHONE: (____)_____ **ZIP CODE:**_____ **EMAIL** *(If different from above)*:_____

PRIMARY INSURANCE INFORMATION:
INSURANCE PLAN:_____ **RELATION TO PATIENT:** ☐ **SELF** ☐ **SPOUSE** ☐ **PARENT** ☐ **OTHER**_____
POLICY HOLDER NAME:_____ **DOB BIRTH**_____ **SSN:**_____
POLICY ID_____ **GROUP ID**_____

SECONDARY INSURANCE INFORMATION:
INSURANCE PLAN:_____ **RELATION TO PATIENT:** ☐ **SELF** ☐ **SPOUSE** ☐ **PARENT** ☐ **OTHER**_____
POLICY HOLDER NAME:_____ **DOB BIRTH**_____ **SSN:**_____
POLICY ID_____ **GROUP ID**_____

INITIAL HERE →_____ **RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM**

I acknowledge that I have received and had an opportunity to read the privacy practices of the office of Affordacare. In reading this information, I understand my right as a patient. I also understand that uses and disclosures may be permitted without prior consent in the event of emergency. If it is necessary for Affordacare to notify me of personal health information, I wish to be contacted in the following manner: Check all that apply:

- ☐ Home Telephone: _____ okay to leave ☐ detailed message or ☐ call back number only
- ☐ Work Telephone: _____ okay to leave ☐ detailed message or ☐ call back number only
- ☐ Cell Telephone: _____ okay to leave ☐ detailed message or ☐ call back number only

Written Communication: Okay to mail to home address? ☐ Yes ☐ No
Personal health or financial information may be released to the following individuals (example: spouse, son, daughter, mother, father, etc)
Name/Relation:_____ Phone:_____
Name/Relation:_____ Phone:_____

INITIAL HERE →_____ **PATIENT FINANCIAL RESPONSIBILITY DISCLOSURE STATEMENT:** Your signature below forms a binding agreement Responsible Party for minor patients (those under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills. **ALL** will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.

RETURNED CHECK POLICY: If payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC) or Return to Maker (RTM), the Patient or Responsible Party will be responsible for the original check amount in addition to a $30.00 Service Charge. Once notice is received of the returned check, Affordacare will send out a letter to notify the Responsible Party of the returned check. If a response is not made within 10 days from the date on the letter by the Patient or Responsible party, the account may be sent over to the District Attorney (DA) and a collection fee will be added to the outstanding balance - in addition to the $30.00 Check Service Charge.

NON PAYMENT ON ACCOUNT: Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that Affordacare has the right to disclose to an outside collection agency all relevant personal account information necessary to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collections, including, but not limited to, interest due at 23% APR, all court costs and Attorney fees, and a collection fee will be added to the outstanding balance.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services, or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

PATIENT SIGNATURE:_____ **DATE:**_____

PRINTED PATIENT NAME:_____

RESPONSIBLE PARTY SIGNATURE_____ **DATE:**_____

PRINTED RESPONSIBLE PARTY NAME:_____