

Acute Injury & Illness Center of Highlands Ranch
9330 South University Boulevard, Suite 100 Highlands Ranch, Colorado 80126

PATIENT INFORMATION

Date: _____

Last Name _____ First Name _____ MI _____ Sex: M _____ F _____

Address _____ Apt # _____

City _____ State _____ Zip _____

Phone: Home: (_____) _____ Work: (_____) _____

Occupation _____ Employer _____

Birth date ____ / ____ / ____ Age _____ Marital status: Single _____ Married _____ Other _____

Social Security # _____ - _____ - _____ Drivers license # _____

Emergency contact not living with you: _____ phone # _____ relationship _____

Primary care doctor _____ phone # _____

Local contact _____ phone # _____

Local Address: _____

HEALTH INSURANCE INFORMATION

Insurance Plan _____ Effective date _____

Address _____ City/State/Zip _____

ID number _____ Group name _____ Group# _____

Policyholder Information: Last Name _____ First Name _____ MI _____

Policyholder's Relationship to Patient: _____

Address _____ Apt # _____ City/State/Zip _____

Social Security # _____ - _____ - _____ Drivers license # _____ Birth date ____ / ____ / ____

Phone: Home: (_____) _____ Work: (_____) _____

Occupation _____ Employer _____

GUARANTOR INFORMATION
(INDIVIDUAL RESPONSIBLE FOR PAYMENT IF DIFFERENT FROM POLICYHOLDER)

Last Name _____ First Name _____ MI _____ Birth date ____ / ____ / ____

Address _____ Apt # _____ City/State/Zip _____

Social Security # _____ - _____ - _____ Drivers license # _____ Relation to patient: _____

Phone: Home: (_____) _____ Work: (_____) _____

Occupation _____ Employer _____

Please review and sign the reverse side.
All sections must be filled in for registration to be complete.

TREATMENT CONSENT

The Acute Injury and Illness Center is an urgent care center. Medical services rendered at this clinic are considered urgent care. Urgent Care is defined as medical, surgical, and related healthcare services for the evaluation and treatment of an injury or illness which a lay person feels requires prompt evaluation and treatment by a healthcare professional. I understand that by signing in for evaluation at The Acute Injury and Illness Center, I am seeking urgent care services. I understand that urgent care may incur additional costs over and above those at my regular physician's office. My health insurance plan may assess additional charges over what I would pay at my regular physician's office. I understand that it is my responsibility to understand these benefits.

MEDICAL AND SURGICAL CONSENT: The signer or his or her dependent is suffering from a condition requiring diagnosis and medical treatment. The signer, does hereby voluntarily agree to diagnostic procedures and services and medical and/or surgical treatment which may be administered to or performed on the patient or his or her dependent under the instruction of the attending physician by the physician, his or her assistants or his or her designees.

The signer understands that x-rays ordered by the evaluating practitioner that are performed by another designated radiology facility and will be billed separately. Laboratory work ordered by the evaluating physician may be forwarded to outlying laboratories for analysis and will be billed separately.

RELEASE OF INFORMATION:

The signer authorizes the physicians at the Acute Injury and Illness Center to disclose all or any part of the patient's record to any person or corporation which is or may be liable under a contract to the physicians of the Acute Injury and Illness Center or to the patient or the employer of the patient for all or part of the physicians charges for its services including but not limited to worker's compensation carriers, insurance companies, welfare funds, or the patient's employer. I understand that following the release of these records neither Acute Injury and Illness Center or its physicians will be responsible for the confidentiality of any documents released in accordance with this consent.

The signer authorizes the treating physician at the Acute Injury and Illness Center to obtain any medical records from prior hospital visits or previous physician evaluations that may be pertinent and important in the diagnosis and treatment of the condition the signer and/or his or her dependent is seeking medical evaluation for today.

PAYMENT AGREEMENT:

Payment for services is expected at time and date that services are rendered. If we file a claim with your insurance carrier, you will be responsible for any co-payment, deductible, and for any services not covered by your insurance company. It is the responsibility of the patient or his/her guardian to verify covered benefits (i.e. urgent care benefits) with your insurance carrier. If we file a claim for work related or auto accident related injuries and the claim is denied, you will be responsible to pay the bill in full. A \$20 fee will be assessed for any returned checks. Unpaid balances may be sent to an independent collection agency if not paid in a timely manner. Interest may be included for any outstanding fees.

I have read the about Acknowledgements and Agreements, and fully understand the same.

I attest that the above information is true and correct to the best of my knowledge. I understand this treatment consent applies to this visit and all future visits.

Signature of Patient _____

Signature of Guardian _____

Guardian's Relationship to Patient _____

Date _____ **Time** _____

Telephone permission granted by (if guardian not present): _____

Witness _____ **Date** _____ **Time** _____