HEATHROW
1125 Town Park Ave., Suite 1011
Heathrow, FL 32746
407.804.9494
407.804.9443 Fax

PERSONAL INFORMATION *(Please Print)*

Patient's Name (Last)	First	Middle Initial	Sex ❒ M ❒ F	Today's Date

Patient's Soc. Sec. No.	Patient Birth Date	Patient Age

Residence Address	City	State	Zip	Marital Status: ❒ Single ❒ Married ❒ Widowed ❒ Divorced

Is this your billing address? ❒ Yes ❒ No
If not, list other address:

Home Phone No.	Cell Phone No.	Work Phone No.

E-mail Address:
❒ Check this box if OK to send Lab and X-ray results by E-mail

Name of Employer (Guardian/Parent's Employer if a Minor)	Occupation	Business Phone

Name of Spouse/Parent	Spouse Employer	Business Phone

How did you hear about us? *Please check all that apply.*
❒ Google ❒ Insurance Company ❒ Hotel
❒ Mail Piece ❒ Web Site ❒ Yellow Pages
❒ Magazine ❒ Chamber ❒ Other _____

Primary Care Physician or specialist (Name, Phone)

Emergency Contact (Name, Address, Phone)	Relationship

Responsible Party (Name, Address, SS#)

HOW DO YOU PLAN TO PAY FOR TODAY'S VISIT? ❒ CASH ❒ DEBIT ❒ CREDIT CARD ❒ WORKER'S COMP

CONSENT FOR TREATMENT AND LIFETIME AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I hereby give consent to Heathrow Urgent Care to provide whatever treatment they deem necessary to the patient above.

I certify that the information I furnish is true and correct. I know it is a crime to fill out this form with facts that I know are false or to leave out facts I know are important.

I hereby authorize Heathrow Urgent Care to submit a claim to my insurance carrier or its intermediaries, for all covered services rendered by the physician(s) and authorize and direct my insurance carrier or its intermediaries to issue payment check(s) direct to the physician(s) rendering the covered services for the next 12 month period.

I hereby authorize Heathrow Urgent Care to furnish complete information requested by my insurance carrier or its intermediaries regarding services rendered.

I further agree that I am responsible for paying my balances which remain after insurance payments have been made, including any cost of collection or legal fee incurred to collect these balances.

SIGNATURE/PATIENT AUTHORIZATION _____ SIGNATURE OF RESPONSIBLE PERSON IF OTHER THAN PATIENT _____ DATE _____

MEDICARE / MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare/Medigap benefits be made either to me or on my behalf to Heathrow Urgent Care for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

BENEFICIARY SIGNATURE _____ DATE _____

MEDICAL RECORDS AUTHORIZATION

I hereby authorize the physician to release any information, including HIV results, acquired in the course of my treatment necessary to process claims, or for continuation of treatment by my primary care physician or a specialist.

SIGNATURE _____ DATE _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birth Date _____

Signature _____

Date _____