WILLIS URGENT CARE

Excellent

Compassionate

Care and

Affordable!

1217 Interstate 45 N, Suite 300
Willis, Texas 77318
Tel: (936)-228-7598 **Fax**: (936)-228-7599
www.willisurgentcare.com
Email: contact@willisurgentcare.com

Patient Name			Social Security Number
Date of Birth	Marital Status S M D W P	Address	
Home Phone	Ok to leave message? Yes No	City	State Zip Code
Email Address		Employer's Name/Occupation	
Mobile Phone or Pager		Work Phone	Ok to leave message? Yes No
Emergency Contact	Relationship	Emergency Contact Phone	
Primary Care Physician		**Insurance** Name of Insurance co. _____	
Pharmacy with two cross streets _____ _____		ID# _____ Group# _____ Phone# _____	

Parent/Guardian or Primary Insured Info (if patient is a minor or is not the primary insured)

Parent/Guardian or Primary Insured Name			Social Security Number
Date of Birth	Relationship to patient	Address *(if different from above)*	
Home Phone		City	State Zip Code
Work Phone		Employer's Name	

----------**Please Read and Sign Below**----------

Benefits Assignment
I hereby authorize the assignment of benefits (payments) directly to Willis Urgent Care Clinic for all my insurance claims related to services received. I agree to pay any and all charges that exceed or are not covered by my insurance

Signature of Responsible Party: _____ Date: _____

Record Release
I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature of Responsible Party: _____ Date: _____

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Where did you hear about Willis Urgent Care?

_____ Friend _____ Letter _____ Mailer _____ Instagram _____ Internet

_____ Facebook _____ Radio _____Relative _____Signage _____Work _____ Other

Acknowledgement of Financial Policy

I understand Willis Urgent Care will obtain demographic information including mailing address, contact phone numbers, and email address. I understand that Willis Urgent Care will copy my insurance card and driver's license. I further understand it is my responsibility to notify Willis Urgent Care in the event of insurance coverage change or any demographic information changes.

_____ (initial) I understand if I do not have insurance coverage, I will be responsible for series rendered at the time of service.

- I understand that Willis Urgent Care does not accept Medicaid.
- I understand payment of co-payments, deductibles, and percentages not covered by my insurance carrier are due at the time services are rendered.
- Willis Urgent Care handles many kinds of insurance, and we may not have all the details of your insurance benefits. Some of your questions can best be answered by a representative of your insurance company.

_____ (initial) Your insurance coverage will be verified, and your co-pay will be determined.

- All co-pays are expected at the time of service and must be paid prior to insurance being submitted.
- If I am a Medicare recipient, I understand I will be responsible for annual deductibles, 20% coinsurance, non-covered services, and any charges Medicare states I am responsible for.

I hereby authorize Willis Urgent Care to furnish my insurance company with all the information which the insurance company may request concerning my present illness or injury. I hereby assign Willis Urgent Care all money to which I am entitled for medical expenses related to the service reported. I understand I am financially responsible to Willis Urgent Care for charges not covered by my insurance company.

Patient Name: _____ Patient DOB: _____

Responsible Party: _____ Date: _____

Responsible Party Signature: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Dear Patient,

Willis Urgent Care is committed to maintaining the integrity of your protected health information and complies with all applicable state and federal regulations.

The federal privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA) have taken effect April 14,2003. In support of our policy of complying with all applicable regulations, Willis Urgent Care provides patients with HIPAA Notice of Privacy Rights.

While not required to receive treatment at Willis Urgent Care, we are obligated under federal regulations to ask that you sign an acknowledgement of the HIPAA Privacy Notice being made available to you.

Receipt of HIPAA Privacy Notice

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how Willis Urgent Care may use and disclose my protected health information. I understand that Willis Urgent Care reserves that right to change the privacy notice and that a copy of the revised notice will be made available to me.

Printed Name:_____ Date: _____

Signature of Patient or Parent/Guardian: _____

Your Protected Health Information Designees:

Please list below those individuals (designees) with whom we can briefly discuss your billing (invoicing, copays, balance, etc.) or medical information (reason for visit, lab or test results, prescription information). This person (designee) will also be able to call the office on your behalf.

		Billing	Medical
Name:_____	Relationship: _____		
Name:_____	Relationship: _____	_____	_____
Name:_____	Relationship: _____	_____	_____

OFFICE USE ONLY

We attempted to obtain a written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained, because: ___ Individual refused to sign
___ Communication barriers prohibited obtaining the acknowledgment
___ An emergency prevented us from obtaining acknowledgment
___ Other_____

Signature:_____ Date: _____