

# ACCUCARE

## OF NORTH FLORIDA

### Urgent Care

5685 Norwood Avenue  
 Jacksonville, FL 32208  
 Phone: 904-764-4467

**Please present your insurance card at time of check-in.  
 Settlement of patient financial responsibility is expected at time of service.**

TYPE OF VISIT:  Insurance (present card at check-in)  Self-pay (payment due at time of service)  On-the-job injury  Other: \_\_\_\_\_

<b>Patient Name:</b>		
Last:	First:	Middle:
Date of Birth:	Social Security Number:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	Spouse Name:	
Street Address:		City, State, ZIP
Home Phone: <input type="checkbox"/> Preferred	Cell Phone: <input type="checkbox"/> Preferred	Work Phone: <input type="checkbox"/> Preferred
<i>May we leave a message regarding your care (x-ray, lab results) on your preferred phone?</i> <input type="checkbox"/> Y <input type="checkbox"/> N	Employer:	Occupation:

**Please state your reason for today's visit:**

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<b>Are you experiencing any of the following? Please stop and notify attendant immediately.</b>	
<input type="checkbox"/> SEVERE chest pains <input type="checkbox"/> SEVERE shortness of breath <input type="checkbox"/> Uncontrolled bleeding <input type="checkbox"/> Allergic reaction <input type="checkbox"/> Any other life-threatening condition	
<b>Is this an on-the-job or other work-related injury?   <input type="checkbox"/> Y   <input type="checkbox"/> N</b> <b><i>If so, please complete the following:</i></b>	
Employer Name:	Supervisor:
Street Address:	City, State, ZIP
Description of Injury or Symptoms:	Date of Injury:
<b>How did you hear about us?</b>	
<input type="checkbox"/> Physician referral (Name: _____) <input type="checkbox"/> Drive-by/signage <input type="checkbox"/> Insurance company directory <input type="checkbox"/> Friend/Relative/Co-worker <input type="checkbox"/> Advertising (Specify: _____)	

<b>Parent or Guarantor's Name:</b>		
<b><i>Complete with name of insured if the patient is not responsible for his or her charges today.</i></b>		
Last:	First:	Middle:
Date of Birth:	Social Security Number:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street Address:		City, State, ZIP
Home Phone:	Work Phone:	Employer:
<b>Insurance Information:</b>		
<b><i>Please notify staff if secondary insurance should be billed.</i></b>		
Carrier:	Subscriber ID:	Group Number:
Policy Holder Name:	Card Number:	Card Date:
Claim Address:		Phone:

<b>Primary Care Physician:</b> <i>Should we fax or mail a copy of your chart?</i> <input type="checkbox"/> Y <input type="checkbox"/> N		
<b>Name:</b>	<b>Phone:</b>	<b>Fax:</b>

<b><u>Emergency Contact (Not living at same residence):</u></b>		
<b>Name:</b>	<b>Phone:</b>	<b>Relation:</b>

<b><u>Medical History:</u></b>
List all medications and doses (including vitamins):
List all known allergies and specific reactions:

List any additional conditions you would like to notify or discuss with the physician:
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**Authorization and Release**

**Authorization For Treatment:** I voluntarily consent to the administration and cost of medical and surgical procedures, x-ray, and medication for myself and my dependents.

**Assignment of Insurance Benefits:** I authorize payment directly to this urgent care center for all benefits otherwise payable to me.

**Guarantee of Payment:** I understand that I am financially responsible and agree to pay all of the charges that are not paid or billed to insurance or any other third party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance copays, coinsurances, and deductibles today. If you are unable to verify my insurance at time of service, I will pay in full for all services.

**Release of Records:** I authorize this urgent care center to release (verbal or in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or other health care operations which may be liable to me or my practitioner(s) for charges for this treatment and for quality management, utilization review, transfer, and follow-up purposes.

**Receipt of Privacy Practices:** I acknowledge that I have received and read the Notice of Privacy Practices of this urgent care center.

I understand that a copy of this agreement may be used with the same effectiveness as the original.

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

RESPONSIBLE PARTY \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

REVIEWED BY \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_