
Acute Kids Urgent Care

Frisco Plano McKinney Flower Mound Allen

Patient's Name: _____ Date: _____

Address: _____ Time: _____

Street

_____ Date of Birth: _____

City

State

Zip

Patient's Age: _____ days/weeks/months/years Patient's Gender: Male / Female

Home Phone Number: _____ Other Phone Number: _____

Email: _____ Private Physician: _____

Email address is used for 48 hour patient follow-up by our nurses.

Guardian's Name: _____ Relationship to Patient: _____

Reason for today's visit: _____

Insurance Company: _____

Subscriber Name: _____ Relationship to Patient: _____

Subscriber Date of Birth: _____ Subscriber SSN: _____

m/d/y

The insurance information requested above is frequently not found on your insurance card.

Privacy Practices Policy: Signing below also indicates that you have been given a chance to review a copy of the Acute Kids Urgent Care Privacy Practices Policy and all of your questions regarding this policy have been answered. A copy of this policy is available on request.

Email: Your information is kept confidential. We will never rent or sell your email address. We request your email address in the event we need to contact you. As a courtesy, you may receive a 48 hour patient follow-up, satisfaction surveys, and urgent notices. By providing your email address you are consenting to AKUC sending unsecured emails regarding your child's visit to the provided email address.

Assignment of Benefits: I hereby authorize the release of medical information to my insurance company(s), and assign benefits otherwise payable to Acute Kids Urgent Care. A copy of this is as valid as the original. I understand that payment is due at the time of service, and I am fully responsible for my charges. Revocation: I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization for the purposes stated above. I further release my physician from any liability arising from the release of information to the individual(s) agency designated herein.

Patient / Responsible party

Date m/d/y