

**NEW PATIENT APPOINTMENT**

First Name		MI	Last		
Address		Apt/Unit #	City:	State	Zip code
DOB	SSN		Gender • Male • Female	Preferred Language	
Phone (Home)	(Mobile)	<b>PREFERRED METHOD OF CONTACT:</b> • Phone (Voice) • Text • Email			
Email Address:					
Employer		Employer Phone	Occupation		
<input type="checkbox"/> Worker's Comp Case					
<b>RACE</b>		<b>ETHNICITY</b>		<b>MARITAL STATUS</b>	
White American Indian Asian Native Hawaiian Hispanic	Black or African American Other Alaskan Native Other Pacific Islander Declined	• Hispanic/Latino • Not Hispanic/Latino • Declined		• Single • Married • Widowed • Divorced • Declined	
<b>HOW DID YOU HEAR ABOUT US?</b> • Drive By • Facebook • Google • US Website • Insurance Referral • Physician/Provider Referral • Friend or Family • Yelp • Instagram • Other			Primary Care Provider		
Emergency Contact Name		Phone	Relationship to Patient		
<b>INSURANCE INFORMATION</b>					
Primary Insurance:	Relationship to Insured <input type="checkbox"/> Primary (Self) <input type="checkbox"/> Dependent		<b>PROVIDE NAME &amp; DOB OF PRIMARY HOLDER</b> Name: _____ DOB: _____		
Secondary Insurance:	Relationship to Insured <input type="checkbox"/> Primary (Self) <input type="checkbox"/> Dependent		<b>PROVIDE NAME &amp; DOB OF PRIMARY HOLDER</b> Name: _____ DOB: _____		
<b>FINANCIAL RESPONSIBILITY</b>					
<b>*If patient is a minor financial responsibility must be completed entirely*</b>					
Responsible Party Name <input type="checkbox"/> Self		Relationship to Patient	SSN	DOB	
Primary Phone		Address			
<b>PREFERRED PHARMACY</b>					
Pharmacy Name		Pharmacy Cross Streets or Address if known			
<b>REASON FOR YOUR VISIT TODAY (WRITE BELOW):</b>					



**CONSENT TO TREATMENT**

By signing below, I (or my authorized representative on my behalf) authorize Florida Keys Urgent Care and its staff to conduct diagnostic examinations, tests and procedures to assess, diagnose, and treat my illness(es) and/or injury(ies). I authorize Florida Keys Urgent Care to provide medications, treatment, or therapy necessary to effectively assess and maintain my health. I understand that it is the responsibility of my individual treating healthcare provider(s) to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment. It is my responsibility to pay for services rendered. I understand that Florida Keys Urgent Care will collect payment from my insurance company(ies) on my behalf, but I am ultimately responsible for payment if my insurance does not cover my fees obtained at Florida Keys Urgent Care. I understand my care may have additional charges billed by outside facilities (i.e. labs, x-rays, and splints) that may not be covered by my insurance carrier and therefore will be my responsibility.

**STATEMENT OF LIMITATION REGARDING ADVANCE DIRECTIVE**

Our team is dedicated to delivering the highest quality care in a safe environment that places the patient at the center of our care. The majority of treatments performed at Florida Keys Urgent Care are considered to be minimal risk. It is policy of Florida Keys Urgent Care that if an adverse event occurs during your treatment, the medical team will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatment or withdraw of treatment measures already begun will be ordered in accordance with your wishes, advance directive, or health care power of attorney.

If you do have an Advanced Directive or Living Will and wish to provide us with a copy of the document, we will place a copy in your medical record. In the event a transfer to a hospital is required a copy will be forwarded to the hospital.

**HIPAA NOTICE OF PRIVACY PRACTICES**

Signature below is only acknowledgement that you have received the Notice of our Privacy Practices.

**NOTICE OF PATIENT RIGHTS**

Signature below is only acknowledgement that you have received the Notice of Patient Rights.

**NOTICE OF LIMITATION REGARDING ADVANCE DIRECTIVE**

Signature below is acknowledgement that you understand the limitation regarding advance directive.

**AUTHORIZATION TO DISCUSS MEDICAL INFORMATION**

I hereby authorize the staff of Florida Keys Urgent Care to disclose medical information (results of tests, care plan, medications, diagnosis, appointment times/dates, etc.), to the parties listed below.

Individual(s) authorized to receive information:

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Phone: \_\_\_\_\_

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Phone: \_\_\_\_\_

I understand,

- This authorization will remain in effect from the date signed below until the patient revokes it.
- I may revoke this authorization in writing, delivered by patient to Florida Keys Urgent Care.
- This authorization is giving Florida Keys Urgent Care the right to discuss my medical information with the one or more individuals listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by the HIPAA.
- I may refuse to sign this authorization and Florida Keys Urgent Care will not condition treatment or payment on my providing authorization.

**Patient Signature (or Legal Guardian)** \_\_\_\_\_

**Name (Printed)** \_\_\_\_\_

**Date:** \_\_\_\_\_

## Assignment of Benefits/Right to Payment and Patient Responsibility Form

I, the undersigned, irrevocably assign to the provider/entity Florida Keys Urgent Care (“Provider”), all of my rights and benefits and any other interests that I have in any medical insurance plan, health benefit plan, indemnity plan, trust fund or other source of payment for healthcare services (each a “Plan”) in connection with medical services provided by Provider, its employees and agents. I understand that this document is a direct assignment of my rights and benefits under my Plan.

I instruct my insurance company to pay Provider directly for the professional or medical expense benefits payable to me. If my current policy prohibits direct payment to Provider, I instruct my insurance company to make out the check to me and mail it directly to Florida Keys Urgent Care, 2506 N. Roosevelt Blvd. #103, Key West, FL 33040 for the professional or medical expense benefits payable to me under my Plan as payment towards the total charges for the services rendered. In addition, I agree and understand that any funds I receive by my insurance company due for services rendered by Provider will be immediately signed over and sent directly to Provider.

Patient Responsibility: I acknowledge and agree that I am responsible for all charges for services provided to me which are not covered by my Plan or for which I am responsible for payment under my Plan. To the extent no coverage exists under my Plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by my Plan. A 3.99% service fee will be added to credit card payments.

A photocopy of this Assignment shall be considered as effective and valid as the original.

\_\_\_\_\_  
Signature of Patient/Person Legally Responsible

Date: \_\_\_\_\_

\_\_\_\_\_  
Print Name of Patient/Person Legally Responsible

\_\_\_\_\_  
Relationship to Patient  
(If signed by Person Legally Responsible)