Family First
URGENT CARE
WE CARE FOR YOU LIKE FAMILY

PATIENT INFORMATION	
Last Name/ First Name:	DOB:

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

☐ I have been informed/reviewed this office's Notice of Privacy Practices that explains how my protected health information (PHI) will be used and disclosed. I understand that I am entitled to receive a copy of this document at my request and authorize the use and distribution as described. **Initial: _____**

FINANCIAL POLICY

Thank you for selecting Family First Urgent Care for your healthcare needs; **full payment is expected at the time of service**. If the patient is a minor the parent, guardian or adult accompanying the child will be financially responsible regardless of legal guardianship. **As a courtesy to you, we will bill your insurance provider however it will be your responsibility for co-payments, co-insurances and deductibles not met at the time of your visit or procedure. In addition, any referrals, authorizations or additional services such as X-rays, laboratory, injections, and durable medical equipment (DME) will be your responsibility if not covered by your insurance carrier**. **If your insurance company does not cover a service provided you will be responsible financial party**. If we have not received payment from your insurance company within thirty (30) days, you will be responsible for the balance due.

Family First Urgent Care accepts, cash, credit cards, and checks. Please note that a returned check is subject to an additional $75.00 fee and in addition to legal action according to Texas penal codes. If a balance on your account is unpaid for 30 days your care and access to Family First Urgent Care, our providers and/or affiliates will be subject to permanent termination. Your account may also be referred to an outside collection agency. Expenses incurred by Family First Urgent Care to collect outstanding balances shall be the responsibility of the person signing this agreement. This notice fulfills our obligation to notify you of the possibility of collection action if your account is not resolved within 30 days. **Initial: _____**

APPOINTMENT POLICY/LATE APPOINTMENTS (WELLNESS ONLY)

☐ Reserved appointment time in any specialist office is limited & valuable. It is extremely important that all patients honor their reserved appointments. Failure to do so deprives our other patients from receiving needed care in a timely fashion. Our office policy stipulates that failure to give sufficient warning to keep a scheduled appointment, (24 hours advance notification), will result in a **$30.00** fee being charged. The patient is solely responsible for payment of this charge. We reserve the right to reschedule your appointment if you are more than 15 minutes late.

Initial: _____

CONSENT OF CARE

I give permission to Family First Urgent Care, its physicians, affiliates, and medical personnel to provide medical services, including but not limited to x-rays, laboratory, administration of medications, anesthetics and any treatment recommended by the physician to me/child.

I authorize my insurance benefits to be paid directly to the physician and authorize Family First Urgent Care and/or any of its affiliates to release any information required to process my claims, remit payment or secure payment for the services provided to me.

I authorize Family First Urgent Care to disclose my current and previous medical records, consultation and treatment plans, to my referring physician, other healthcare providers, and hospitals that will participate in my care. I understand that by signing this form I am seeking medical care until I withdraw consent to Family First Urgent Care privacy officer in writing.

I ACKNOWLEGE I HAVE BEEN INFORMED OF FAMILY FIRST URGENT CARE OPERATING PROCEDURES. MY SIGNATURE AUTHORIZES MY PERMISSION TO CONTINUE CARE WITH FAMILY FIRST URGENT CARE INCLUDING ANY OF ITS PROVIDERS, AFFILIATES AND/OR ASSOCIATES.

Signature: _____ Date: _____

Witness: _____ Date: _____