Family First URGENT CARE
WE CARE FOR YOU LIKE FAMILY

2510 S. Loop 336 West, Suite 115 Conroe Texas 77304
Tel: 936.235.2825 ❖ Fax: 936.235.2826

PATIENT INFORMATION/DEMOGRAPHICS

Last name:	**First:**	**Middle:**	**Date of Birth:**	**Age:**
Address:		**City/State/Zip:**		
Email:		**Social Security: (Required if using insurance)**		
Phone:		Marital Status: ☐ Married ☐ Divorced ☐ Single		Sex: ☐ M ☐ F
Primary Care Physician/Phone:				
Employer: (Name and Address)		Employer Phone:		
In Case of Emergency: (Name of a local friend or relative)		Relationship/Phone		

How did you hear about us? ☐ Drive By ☐ Walk in/Location ☐ Internet ☐ Word of Mouth ☐ Family/Friend ☐ School Referral

NON-INSURED PATIENT DISCLOSURE

☐ I DO NOT have health insurance will be responsible for services rendered at Family First Urgent Care. **INITIAL:** _____

INSURANCE CARRIER INFORMATION

Insurance Name/Address/Phone:	Policy ID:	Group:
Policy Holder Name:	**Policy Holder DOB:**	**Relationship to Patient:** ☐ Self ☐ Spouse ☐ Child

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 verify your coverage and 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. Please be aware C2K Health & Wellness dba Family First Urgent Care will bill as an Urgent Care facility. We may be a provider with your insurance however the individual provider, professional service group may or may not be a covered provider of service. Covered services are determined by your carrier. **If your insurance company does not cover a service provided or your insurance applies services as out of network, you will be the 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. **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 policy holder. This notice fulfills our obligation to notify you of the possibility of collection action if your account is not resolved within 30 days. Family First Urgent Care accepts, cash, credit cards, and checks. Please note all returned checks are subject to an additional $75.00 fee. Issuances of a bad check charges are class C misdemeanors & will be filed with Montgomery County Worthless Check Department.

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

Patient Signature: _____ Date: _____

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MEDICAL HISTORY

Patient Name: | **DOB:**

Reason for today's visit: (include date of onset and current symptoms)

Preferred Pharmacy: (Phone and Location)

Allergies: ☐ No known Allergies ☐ I am allergic to:

(Females) Are you pregnant? ☐ No ☐ Yes _____weeks/months
Date of last menstrual cycle: _____

Current Medications: Please list all prescriptions, non-prescriptions, vitamins, supplements dosages and how often

Current and Past Medical History:

☐ Headaches ☐ High Blood Pressure ☐ Arthritis ☐ Bone/Joint Disease ☐ Prostate Disease ☐ Gastritis/Ulcer ☐ Depression/Anxiety
☐ Diabetes ☐ Asthma/COPD ☐ Chest Pain ☐ Heart Disease ☐ Hepatitis ☐ Gout ☐ HIV
☐ Cancer (Type): _____ ☐ Other:_____

Family History: (Check all that apply) ☐ Heart Disease ☐ Stroke ☐ Arthritis ☐ Osteoporosis ☐ Alzheimer's ☐ Gout ☐ Mental Illness
☐ Cancer (Type): _____ ☐ Other:_____

Have you had surgery in the past? ☐ No ☐ Yes If yes, Type/Date:

Do you smoke/chew tobacco? ☐ No ☐ Yes _____Cigarettes _____Packs/Day _____Cigars _____Per Day

Do you use drugs? ☐ No ☐ Yes (if yes, how often & what)

Do you drink alcoholic beverages? ☐ No ☐ Yes ☐ Beer ☐ Wine ☐ Liquor If Yes, how often? ☐ Socially ☐ Rarely ☐ Daily

MINOR CONSENT (FOR MINORS ONLY)

I, _____, being the parent or guardian of the above listed patient do hereby request and authorize Family First Urgent Care, its providers, affiliates and staff to perform medically necessary services including but not limited to x-rays, administration of medication and anesthetics which are deemed advisable by the provider. **Initial:** _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

This office Notice of Privacy Practices is available on our website (www.familyfirstuc.com) and at check in (on your clipboard). This 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: _____**

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 FINANCIAL POLICY. MY SIGNATURE AUTHORIZES MY PERMISSION TO CONTINUE CARE WITH FAMILY FIRST URGENT CARE INCLUDING ANY OF ITS PROVIDERS, AFFILIATES AND/OR ASSOCIATES.

Patient Signature: _____ Date: _____

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PATIENT INFORMATION

Patient Last Name/ First Name:	DOB:

HIPAA – AUTHORIZATION TO RELASE PROTECTED HEALTH INFORMATION

I give my authorization to release my protected health information including results of my laboratory test, X-ray and/or any test and treatment plans to the listed designated individuals/entities. I understand that Family First Urgent Care may leave voice mail, send electronic correspondence or fax results pertaining to appointment information, financial information and/or treatment plans. I understand that I may withdrawal my consent at any time and will submit my request in writing to Family First Urgent Care privacy officer.

My Spouse (Name):	**Phone No.:**
My Child (Name):	**Phone No.:**
Personal Representative (Name):	**Phone No.:**
Other (Name):	**Phone No.:**
Other (Name):	**Phone No.:**
Other (Name):	**Phone No.:**
Other (Name):	**Phone No.:**
Other (Name):	**Phone No.:**

Additional Instruction:

☐ I **DO NOT** wish to give anyone else permission to access my health information.

THIS AUTHORIZATION FOR RELEASE OF INFORMATION COVERS THE PERIOD OF HEALTHCARE FOR ONE YEAR FROM MY SIGNATURE BELOW. I AUTHORIZE FAMILY FIRST URGENT CARE, ITS PROVIDERS, AFFILIATES AND/OR ASSOCIATES TO USE THIS INFORMATION FOR CONTINUITY OF CARE, MEDICAL TREATMENT, CONSULTATION, BILLING OR CLAIMS PAYMENT, OR OTHER PURPOSES AS NEEDED. (IF THE PATIENT IS A MINOR, THE PARENT/GUARDIAN FILLING THIS FORM GIVES AUTHORIZATION TO RELEASE THE CHILD'S PROTECTED HEALTH INFORMATION INCLUDING RESULTS OF MY LABORATORY TEST, X-RAY AND/OR ANY TEST AND TREATMENT PLANS TO THE LISTED DESIGNATED INDIVIDUALS/ENTITIES WHO ARE AUTHORIZED TO BRING MY CHILD TO HIS/HER APPOINTMENTS.)

Signature: _____ Date: _____

Witness: _____ Date: _____

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