



2510 S. Loop 336 West, Suite 115 Conroe Texas 77304
14420 HWY 105 E Suite 104, Cut and Shoot, TX 77306
Tel: 936.235.2825 ❖ Fax: 936.235.2826

Last name:		First:	Middle:	Date of Birth:	Age:
Address:			City/State/Zip:		
Email:			Social Security: (Required if using insurance)		
Phone:		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
		Race: <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> African Amer. <input type="checkbox"/> Hispanic			
		Other: _____			
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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child

Thank you for choosing
us to care for you!



Please fill out all registration forms



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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



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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 ACKNOWLEDGE 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: _____

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 ACKNOWLEDGE 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:
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HIPAA – AUTHORIZATION TO RELEASE 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.:

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: _____