Summit Urgent Care Clinic (Please Print legibly, thank you.)

I am covered by: MEDICARE TRICARE MEDICAID (CIRCLE THE ONES THAT APPLY TO YOU)

PATIENT'S INFORMATION: (PLEASE USE LEGAL NAME, NOT A NICKNAME)

LAST NAME:	FIRST NAME:	MIDDLE:	
Social Security #: _ _	Birth date (Month/Day/Year) :		Gender: ☐M ☐F
STREET ADDRESS/APT#:	CITY:	STATE:	ZIP CODE:
P.O. BOX & ZIP CODE :	PRIMARY PHONE #: ( )	SECONDARY PHONE #: ( )	

Marital status: (circle the one that applies) Single / Mar / Div / Sep / Wid

Employer:	Employer Address/City, State, Zip Code:	Phone number:	Job Title:
		( )	

REFFERED TO CLINIC BY: (check one)	☐Family	☐Friend	☐Yellow Pages	☐Insurance	☐Other
E-mail Address:			Please continue down to Policyholder information.		

Is patient a child? ☐Yes ☐No

Name of Parent / Guardian:	Birth date:	Address, City, State, Zip Code:	Home phone no.:
	/ /		( )

Is Parent/Guardian a patient here? ☐Yes ☐No

Employer:	Employer address/ City, State, Zip Code:	Employer phone number:	Job Title:
		( )	

List other family members seen here:

PRIMARY POLICYHOLDER: (Please complete this portion and give your insurance card and I.D. to the receptionist.)

ALL INFORMATION IS REQUIRED FOR BILLING PURPOSES

Please Indicate Primary Insurance: **IN-NETWORK INSURANCES ARE LISTED BELOW (Check the one that applies).**
**** If we are out of network with your insurance or you are not insured full balance will be due at the conclusion of your visit.**

☐BCBS	☐HealthScope/ACCESS	☐AETNA	☐CIGNA	☐HEALTHSMART	☐GREAT WEST	☐TX TRUE CHOICE	☐MEDICAL CARE REF GRP
☐Advantage Care Network		☐WORKMAN'S COMP / DOI: / /			Out-of-Network Insurance:		

Primary Policyholder's Name	Policyholder's DOB:	SS#	Address, City, State, Zip Code:	Phone Number:
	/ /			

Patient's relationship to Insured:	☐Self	☐Spouse	☐Child	☐Other	
Name of Secondary Insurance (if applicable):		Policyholder's Name:		Policyholder's DOB:	Policyholder's SS#:
Patient's relationship to Insured:	☐Self	☐Spouse	☐Child	☐Other	Policyholder's address:

IN CASE OF EMERGENCY PLEASE CONTACT:

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Other phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Summit Urgent Care or insurance company to release any information required to process my claims.

Please remember that Insurance is considered a method of reimbursing the fees paid to the doctor and is not a substitute for payment. Some companies may pay fixed allowances for certain procedures. They sometimes refer to as "Reasonable and Customary fees". We do not accept this as payment in full (unless otherwise restricted by law or agreement we may have with your insurer). Also, some of the insurance companies only pay a percentage of the charge. It is your responsibility to pay any deductible amounts, co-insurance payments, or any other balance not paid for by your insurance. IN ORDER TO CONTROL YOUR COST OF BILLINGS WE DO REQUEST THAT OUR CHARGE FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT. In the event the account is turned over for collections, the collection fees, and/or legal fees, including attorney fees, shall be your responsibility.

I hereby assign all medical, and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance and other health plans, to the facility listed in the top header of this page. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as a valid original. I hereby authorize said assignee to release all information necessary to secure the payment, via Fax Transmittal or hard copy.

I acknowledge that this facility does not accept Medicare, Medicaid, or Tricare and that I MAY NOT bill for the services myself.

If you're insurance company is out- of- network it is your responsibility to pay any balance not covered by insurance.

Signature:_____ **Date**:_____