Visit ID _______________ Copay $_______
Pharmacy_____________

Urgent Care South
143 White Oak Trail, Warrior AL 35180
Phone: (205) 647-1819

IS TODAY'S VISIT WORK RELATED? IF YES – PLEASE LET THE FRONT DESK KNOW

Patient Last Name: ________________________________ **First Name:**_____________________________ **MI:** ______

Date of Birth: ______/______/______ **Social Security Number:**_________-_________-_________ **Gender: M / F**

Mailing Address: ____

City: _______________________________________ **State:** _________ **Zip Code:** ___________________

Email: ____ **Cell Phone** ________________________

Primary Care Doctor:________________________________ **Chief Complaint:**_________________________________

Best Phone Number to Reach You: _______________________________________ **Cell or Home or Work (circle one)**

How Did You Hear About Us? **Friend/Family** **Facebook** **Email** **Mail**

Emergency Contact:

Name: ________________________________ **Phone Number:** ______-_______-___________**Relationship**____________

Primary Insurance Policy Holder / Party Responsible for Payment if DIFFERENT from information above:

Name: ____ **Relationship to Patient:** ________________________

Date of Birth: ______/______/______ **Gender: M / F** **Social Security Number:**__________-_________-__________

Responsible Party Address, Phone, and Email if DIFFERENT from above

Mailing Address: ____

City: _______________________________________ **State:** _________ **Zip Code:** ___________________

Phone: _________________________________ **Email:**____

I authorize Rural Primary Care South/Urgent Care South to release my Private Health Information to the individuals below (please list):

Name: ____ **Relationship**_____________________________

Name: ____ **Relationship**_____________________________

Privacy, Billing, and Other Important Information

I authorize Rural Primary Care South/Urgent Care South to contact me: (1) at the number(s) listed above and leave a voicemail if I am unavailable; (2) send text messages to phone number(s) listed above; (3) send email messages to email(s) listed above. I have read and reviewed Rural Primary Care South/Urgent Care South's Billing Policies and Privacy Policy. We will file a claim with your insurance company for the services provided, in the event of non-payment you will be responsible the charges incurred today. I authorize release of any information concerning my (or my child's) health care and treatment for the purpose of evaluating and administering claims of insurance benefit. I authorize Rural Primary Care South/Urgent Care South to charge my credit card for charges allowed, but not paid for, by my insurance company (patient responsibility). I hereby authorize payment of insurance benefits, otherwise payable directly to me, to the Provider who has assigned those to Rural Primary Care South/Urgent Care South . I consent to care and treatment of myself (or my child) by the attending provider and his/her associates and assistants.

X____ Date: _________________
(Signature of patient or parent/guardian of minor)

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Pharmacy_____________