Today's Date: _____ **Reason for Visit:** _____

Last Name: _____ **First Name:** _____ **MI:**_____

Social Security Number: _____ **DOB:** _____ **Gender:** _____

Permanent Address: _____ **Apartment Number:** _____

City: _____ **State:** _____ **Zip Code:** _____

Secondary Address: _____ **Apartment Number:** _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone Number: _____ **Cell Phone Number:** _____

Marital Status: Single _____ **Married** _____ **Separated** _____ **Divorced** _____ **Widowed** _____

Race: _____ **Ethnicity:** _____ **Preferred Language:** _____

Primary Care Physician: _____ **How did you hear about our office?** _____

Local Preferred Pharmacy Name and Location _____

Emergency Contact and Phone Number: _____

Email Address: _____

*** PLEASE COMPLETE IF YOU HAVE HEALTH INSURANCE ***

Insurance Company Name: _____

Member ID: _____ **Group Number:** _____

Address for claims: _____

Policy Holder Name: _____ **DOB:** _____ **Relationship to patient:** _____

Secondary Insurance: _____

***** PLEASE NOTE THAT COPAYMENTS AND DEDUCTIBLES ARE COLLECTED UPON CHECK IN *****

Insurance Policy: If your insurance coverage is with a plan that we have a participating agreement with, we will file a claim on your behalf. Our staff will do their best to determine what financial responsibilty lies with the patient and collect these amounts upon checking in. Please remember that it is ULTIMATLEY the patients' responsibility to be familiar with their individual insurance benefits. Any remaining balance due from the patient after insurance processing will be billed to you and is payable within 45 days of insurance posting. If your insurance company requires an authorization for services provided to you from a provider within you insurance network, it is the patients' responsibility to initiate and obtain the referral. Furthermore, you are hereby authorizing Suncoast Urgent Care Center, LLC and its billing representatives to apply for insurance benefits on your behalf. I certify the information reported with regards to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this and any future claims.

_____	_____	_____
Patient Name (Please Print)	**Patient Signature (Parent or Guardian if under 18)**	**Date**

*** CONSENT TO TREATMENT/ SERVICES (SIGNATURE REQUIRED) ***

By signing this form, I am requesting services from the physicians and staff of Suncoast Urgent Care Center, LLC and hereby consent to treatment as recommended. I permit a copy of this authorization to be used in place of the original.

Patient Name (Please Print)	Patient Signature (Parent or Gaurdian if under 18)	Date

*** Patient Receipt of HIPAA Privacy Notice ***
Suncoast Urgent Care Centers, LLC

Suncoast Urgent Care Centers, LLC is committed to maintaining the integrity of your health information and complies with all applicable state and federal regulations. The federal privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA) have taken effect April 14, 2003. In support of our policy of complying with all applicable regulations, Suncoast Urgent Care Centers, LLC provides patients with the HIPAA Notice of Privacy Rights. While not required in order to receive treatment at Suncoast Urgent Care Centers, LLC, we are obligated under the federal regulations to ask that you sign an acknowledgment of the HIPAA Privacy Notice being made available to you. It is the office policy of Suncoast Urgent Care Centers, LLC not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, or cell phone. When returning telephone calls, if your answering machine picks up, we cannot leave a message unless the name and telephone number is on the recorded message identifying your residence. Also, information will not be left with an unauthorized person who may answer your telephone.

I authorize Suncoast Urgent Care Centers, LLC staff to leave medical information pertaining to my care by the following methods and will assume responsibility of notifying Suncoast Urgent Care, LLC, in writing, if this information changes:

Home Phone: YES / NO **Cell Phone:** YES / NO
Answering Machine: YES / NO **Voice Mail:** YES / NO

Please list people authorized to receive your health information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how Suncoast Urgent Care Centers, LLC may use and disclose my protected health information. I understand that Suncoast Urgent Care Centers, LLC reserve the right to change the privacy notice and that a copy will be made available to me.

_____
Printed Patient Name

_____ _____
Patient Signature **OR** Parent/Guardian if under 18 Date

*****OFFICE USE ONLY*****

To be completed only when patient declines to sign acknowledgment

( ) Check here if patient declined to sign acknowledgment

Staff Signature: _____ Date: _____

@ Trinity 10730 State Road 54, #104 New Port Richey, FL 34655 Phone (727) 372-3888 Fax (727) 372-3820