

APPLICATION FOR TREATMENT

I, _____, hereby authorize the staff of PMC Urgent Care to provide me with
Patient Name

any and all medical services deemed necessary by the provider. I agree to inform PMC Urgent Care if I have any concern about my medical treatment at the time services are rendered.

I understand that if my symptoms persist I should seek additional medical care. _____
Initials

We/ I, _____, the parent(s) / guardian(s) of
Parent/Guardian Name

_____ give PMC Urgent Care and its employees the right
Patient Name

to treat my son / daughter or legal ward.

All payments for services are due at the time of visit. (This includes co-pays/deductibles for insured patients and all fees for non-insured patients). A RETURNED CHECK FEE OF \$35 WILL BE APPLIED TO YOUR BILL FOR RETURNED CHECKS.

I authorize release of information and/or copies of my medical records to my insurance carrier, physician, and/or other third party payers. My insurance carrier and/or other third party payers are hereby requested and authorized to pay direct to the treating facility's office. If for any reason the insurance carrier denies my claim and/or declines to pay any services, I understand and agree to pay the full amount of my bill.

Patient/Parent or Guardian Signature

Date

Witness Signature

Date

I authorize PMC Urgent Care to notify my Primary Care doctor, Dr. _____, of my office visit at PMC Urgent Care today. Y or N _____ initials

Returning Patients- Please Fill Out the Following Information

Name: _____ DOB: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Address: _____

Insurance Information

Insurance Company: _____

Member ID: _____ Group #: _____

Reason for visit: _____

Is this an Auto Accident?

Y or N

Is this Work Related?

Y or N