AllKids Urgent Care

1455 S Stapley Dr, Ste 1 – Mesa AZ 85204 • 10720 E Southern Ave, Ste 112A - Mesa AZ 85209 • 480.633.1111 • *www.mysickkid.com*

(Revised 01/19)

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH	SEX MALE ____ FEMALE ____

PARENT/LEGAL GUARDIAN INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH	SOCIAL SECURITY # - -
RELATIONSHIP TO PATIENT	**DRIVER LICENSE NUMBER**	**STATE**	**HOME PHONE** ( )	**CELL PHONE** ( )
ADDRESS (STREET AND APT)		**CITY**	**STATE**	**ZIP**
EMAIL ADDRESS		**EMPLOYER**		**WORK PHONE** ( )

PATIENT'S INSURANCE INFORMATION - Please present insurance card(s) to the receptionist

PRIMARY INSURANCE	POLICY NUMBER	GROUP NUM	SECONDARY INSURANCE	POLICY NUMBER	GROUP NUM

Is the parent/guardian listed above the primary insured (circle one)? YES NO (If Yes, skip to the next section)

PRIMARY INSURED LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH	SOCIAL SECURITY # - -
RELATIONSHIP TO PATIENT	**DRIVER LICENSE NUMBER**	**STATE**	**HOME PHONE** ( )	**CELL PHONE** ( )
ADDRESS (STREET AND APT)		**CITY**	**STATE**	**ZIP**

PRIMARY CARE PHYSICIAN INFORMATION

NAME	PRACTICE NAME	PHONE ( )	FAX (If known) ( )

HOW DID YOU HEAR ABOUT US?

❑ PCP Referral ❑ Facebook ❑ Yelp ❑ Friend ❑ Drive-by/walk-by ❑ 3TV Morning Show ❑ Other urgent care ❑ Other _____

EMERGENCY CONTACT INFO - Someone who does NOT live with you but can reach you

LAST NAME	FIRST NAME	RELATIONSHIP	HOME PHONE ( )	CELL PHONE ( )
ADDRESS (STREET AND APT)		**CITY**	**STATE**	**ZIP**

Assignment of Benefits: In the event the patient, his/her authorized representative or the guarantor signing below, is entitled to benefits of any type arising out of any policy of insurance insuring the patient or any other party liable for the patient, those benefits are hereby assigned to AllKids Urgent Care for application to the patient's bill. Such payment shall discharge the insurance company of any obligation under the policy to the extent that the payment has been made accordingly to the terms of the policy. The undersigned shall remain responsible for any and all charges not paid by the insurance company and/or covered by this assignment. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable for this patient, is hereby assigned to AllKids Urgent Care.

Parent/Guardian Signature: _____ Date: _____

Financial Responsibility: I agree that in return for the services provided to the patient by AllKids Urgent Care and/or any assisting physicians or providers, I will pay the account of the patient prior to discharge or make financial arrangements satisfactory to AllKids Urgent Care. In the event of default, I agree to pay all costs of collections at a 30% collections fee *(This means $100 owed turns into $130 at the collection agency*), and reasonable attorney's fees. A delinquent account (60 days from date of service) may also be charged a $10.00 billing fee and may be charged interest at the legal rate.
IT IS UNDERSTOOD THAT THERE MAY BE AN ADDITIONAL CHARGE FOR X-RAY OR LABORATORY TESTS PERFORMED BY PROVIDERS OF ORGANIZATIONS OTHER THAN ALLKIDS URGENT CARE THAT WILL BE BILLED SEPARATELY.

Parent/Guardian Signature: _____ Date: _____

Consent To Treat And/Or Release: I hereby authorize AllKids Urgent Care and its providers to examine and treat me and/or my child when necessary. I also authorize the release of my/our protected health information (PHI), acquired in the course of examination to carry out treatment, payment and healthcare operations (TPO) on our behalf.

Parent/Guardian Signature: _____ Date: _____