524 Colorado Avenue
Santa Monica, CA 90401
Tel: 310-394-2273
Fax: 310-394-9700
www.SantaMonicaUC.com

PATIENT INFORMATION

Name-Last: _____ First: _____ M. I.: _____

Date of Birth: _____ **SS #:** _____ **Gender:** □ Male □ Female

Address: _____ **DL#:** _____ **Age:** ____

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

Phone Home**:** _____ Cell: _____ Work: _____

Employer: _____

Person to notify in case of emergency:

Name: _____ **Relationship:** _____ **Phone** Home**:** _____

Address: _____

How did you hear about Santa Monica Urgent Care?

□ Yellow Pages □ Friend/Relative □ Employer □ Brochure □ Drive by □ School

□ Internet (site) _____ □ Other: _____

Are you presently under the care of a physician? □ No □ Yes, Physician's Name: _____

Do you have any allergies or reactions to medications? □ None □ Yes, Which one? _____

Do you have any major medical condition? □ None □ Yes, List _____

_____

What current medications are you taking?

	MEDICATION	DOSE	HOW OFTEN
1.			
2.			
3.			
4.			
5.			

I, the undersigned, hereby authorize Santa Monica Urgent Care provide medical procedures to be performed on myself/child. By signing, I fully understand that I am responsible for any fees incurred regardless of insurance coverage or medicare coverage.

Signature: _____ **Date:** _____

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MEDICAL SERVICES AGREEMENT
(READ CAREFULLY BEFORE SIGNING)

Patient's Name: _____

1. **MEDICAL CONSENT**: I consent to any medical treatments or procedures which may be performed on an outpatient basis (including emergency treatment or services), which may include but are not limited to medications, injections, taking of medical photographs, laboratory procedures, and/or x-ray examinations provided to me under the general and special instructions of the physicians, staff, or other health care providers of Santa Monica Urgent Care, Inc. (herein referred to as "SMUC") assisting my care.

2. **FINANCIAL AGREEMENT: I understand that all charges are due at the time of service.** I agree to pay SMUC for all charges for healthcare services and professional services provided to me by physicians and other healthcare professionals. Acceptable forms of payment include Cash, Visa, MasterCard, Discover and Debit card. If I am not insured, I agree to pay for my visit in full at the time of service. If SMUC is a participating provider with my insurance company I understand that my estimated co-pay, coinsurance, deductible and/or any outstanding balances are due at the time of service.

   Patient or Guardian Initials _____

   I understand that my insurance policy is a contract between myself and my insurance company; SMUC is not involved. In order for SMUC to file claims and accept payments from my insurance company, I understand that I must present current insurance information at each visit and that SMUC will need to verify my insurance coverage. Verification of my insurance benefits is NOT a guarantee of payment by my insurance company. In the event that SMUC is not able to verify my insurance eligibility and benefits before my visit, I agree to pay for my visit in full at the time of service. A refund/credit will be issued if my insurance pays for the visit. I also understand that I am financially responsible for any services not covered by my insurance company. When my spouse or a financial guarantor signs this agreement, the spouse or the financial guarantor shall be jointly and individually liable with me. Should my account(s) be referred to an attorney or a collection agency for the collection, the undersigned shall pay the actual attorney's fees (including costs) and collections expenses incurred in addition to the other amounts due. Unpaid accounts referred to outside agencies for collection shall bear interest at the current rate per year from the date of referral.

3. **IN-HOUSE PHARMACY:** I understand that, for my convenience, SMUC can dispense some prescription medications necessary to treat my medical condition(s). I understand that my insurance company will not be billed for medications dispensed and that my pharmacy benefits DO NOT apply to this service. **Any medications dispensed in office are my responsibility and are an additional charge to my responsibility for my office visit.** I also understand that if I prefer to use an outside pharmacy, a prescription can be provided to me at no additional charge.

   Patient or Guardian Initials _____

4. **INSURANCE AUTHORIZATION AND RELEASE:** I request that payment of authorized benefits, including Medicare, and any other government sponsored program, private insurance, and any other health plans be made to SMUC for any services furnished by that provider. To the extent necessary to coordinate my health care or determine liability for payment and to obtain reimbursement for services rendered, I authorize SMUC to disclose portions of or all of my records, including my medical records to any person or corporation which is or may be liable for all or any portion of SMUC's charges, including but not limited to insurance companies, health care service plans, governmental agencies, or worker's compensation carriers. I authorize SMUC to act as my agent to help me obtain any required pre-certification as well as acting as my agent to help me obtain payment from my insurance companies. I authorize my insurance companies to give SMUC any information required to fulfill this function. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.

5. **RELEASE OF MEDICAL INFORMATION:** I hereby authorize SMUC to release any information in my chart to any practitioner, doctor, hospital, or medical institution to whom I may be referred to assist in my care. Additionally, I authorize any request for medical information from any medical practitioner, doctor, hospital, or medical institution to assist in my care.

6. **PERSONAL VALUABLES:** SMUC shall not be liable for the loss of or damage to any money, documents, jewelry, glasses, dentures, furs, or other articles of unusual value and shall not be liable for loss or damage to any personal property.

Santa Monica Urgent Care, Inc. and the patient or the patient's representative, hereby enters into this agreement. The undersigned certifies that he/she has read and agree to the foregoing, and is the patient, the patient's representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

_____	_____		_____	_____
Signature of Patient	DATE	or	Signature of Patient's Representative	DATE
_____	_____		_____	
Medical Practice's Representative	DATE		Name & Relationship of Representative to Patient	