Freedom Urgent Care, PLLC
300 W. Central Texas Expressway, Ste 115
Harker Heights, Texas 76548
Patient Registration Form

I ACKNOWLEDGE I AM A RETURNING PATIENT TO FREEDOM URGENT CARE. I HAVE READ AND FULLY UNDERSTAND ALL RESPONSIBILITIES FOR PAYMENT AND/OR BILLING FOR SERVICES RENDERED FOR TODAY'S VISIT. **I HAVE INFORMED THE PATIENT COORDINATOR OF ANY CHANGES IN MY ADDRESS, PHONE NUMBER OR INSURANCE CARRIER (please initial)_____**

Authorized signature is on file. By signing, I attest that all information provided is true and correct. I authorize the release of any necessary medical information and payment of medical benefits to the physician for services rendered. I understand and agree that:

1) I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read) and understood the notice;

2) I am responsible for all charges incurred including the balance remaining after payment of insurance benefits (as per your insurance contract);

3) Payment is expected on the day services are rendered unless prior arrangements are made; and

4) That the information in this paragraph may not be altered or amended by me.

PRINTED NAME OF PATIENT_____DOB_____

PRINTED NAME OF PARENT OR GUARDIAN_____

REASON FOR VISIT_____

INSURANCE CARRIER_____

(IF YOU ARE AN OCCUPATIONAL MEDICINE PATIENT, PLEASE LIST YOUR COMPANY'S NAME)

Primary Care Provider_____

Patient or Responsible Party Signature: _____Date _____

INSURANCE VERIFIED (STAFF INITIAL):_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____ Date of Birth_____
First name Middle Last Name MM/DD/YYYY

Address:_____
Street City State Zip Code Phone #
(_____)_____

SSN: _____-_____-_____

Hereby authorize/request you ***Freedom Urgent Care***
to release confidential information contained in my medical records or the medical record of my child:

_____,
First Name MI Last Name DOB

Including but not limited to progress notes, history & physical, radiology reports, lab reports, EEG reports, discharge summaries, medication reports, and consultation reports.

I authorize no limits on dates, history of illness, or diagnostic and therapeutic information, including any dependency, HIV, AIDS and/or other communicable diseases. _____ (Initials)

PHI released to: **PLEASE SPECIFY BY LISTING THE NAME(S) OF PERSON OR ORGANIZATION**

Other_____

Patient_____

Guardian_____

Permission is not given_____

_____ _____
Patient/Guarantor's Signature Date