DENTON REGIONAL
Urgent Care Center

NEW PATIENT | UPDATED CONTACT INFORMATION
2520 West University Drive| Suite1154| Denton, TX 76201
Phone: (940) 220-5901 | Fax: (940) 566-1715
www.DentonRegionalUrgentCare.com

Date:_________________ Time:_________________

Patient's Name: ____ Preferred Name:___________________________

Address:____
Street City State Zip

Date of Birth: ______________________________________ Age:_____________________ Gender: M / F

Best Phone Number: ________________________________ Alternate Phone Number:_____________________________

Email: ____ Primary Care Physician:_______________________________
Email address is used for 48 hour patient follow-up by our nurses.

I consent for messages that include my protected health information (ex: lab or radiology results) to be left for me at: (check all that apply) ◯ Voicemail ◯ Email ◯ Mail ◯ Other:_______________________________

Preferred Pharmacy: ____________________________________ Pharmacy Location:______________________________

Reason for today's visit:____

Guardian's Name, If Patient Under 18:__________________________ Relationship to Patient:______________________

Insurance Company:_________________________________ Subscriber Name:___________________________________

Relationship to Patient:_____________________________ Subscriber Date of Birth:____________________________

Insurance Group/Account #:__________________________ Subscriber ID #:_____________________________________

Subscriber SSN:____________________________ Subscriber Address (billing address, if different from above):___________

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Consent for Treatment and Payment Agreement: I consent to Denton Regional Urgent Care's administration and performance of general treatment, use of prescribed medications, performance of diagnostic procedures, tests, cultures, and performance of other laboratory tests that my physician or his designee determines medically necessary or advisable based. I give this consent in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in force until revoked in writing; and a revocation of this consent will not affect the validity of my consent as to acts performed prior to the revocation. I understand that my consent on this form extends to other Denton Regional Urgent Care locations. A photocopy of this consent shall be as valid as the original. I understand that while my consent is voluntary, if I refuse to sign this consent, Denton Regional Urgent Care may refuse to treat me.

Minor/Disabled Patient: If I am signing this consent on behalf of a patient who is under age 18 or impaired in such a way as to make him or her unable to consent to or refuse treatment, I represent to Denton Regional Urgent Care that I have the legal authority to consent to treatment on such patient's behalf and that I do in fact consent to treatment as described in the preceding paragraph. In such a case, references in this form to "I," "me," or "my" are intended as references to such patient where appropriate in the context.

Exposure Testing: I understand that in the case of an accidental exposure to blood or other bodily fluids, state law allows Denton Regional Urgent Care to perform an HIV test without obtaining the patient's consent on a patient who may have exposed a healthcare worker to HIV.

Patient Responsibility for Follow-Up: I understand that it is my responsibility to follow any discharge and/or follow-up instructions Denton Regional Urgent Care may provide to me, including without limitation any recommended home-care and any follow-up examination and/or treatment by other healthcare providers. I accept full responsibility for the consequences of any failure by me to obtain recommended follow-up care and/or to comply with any other discharge instructions related to this Denton Regional Urgent Care visit.

Responsibility for Payment: In consideration of the services Denton Regional Urgent Care will provide to me, I promise to pay Denton Regional Urgent Care's charges for such services. I understand Denton Regional may file its bill with my insurance company, but I understand that it is my responsibility to obtain any referral forms from my primary care physician that my insurance company may require as a condition to its payment for my healthcare service. I understand that the cost of healthcare services provided to me are my personal responsibility, even if I have insurance coverage for such cost, and that I am directly liable to Denton Regional for any portion of such cost that my insurance company or other third-party payer does not pay, for any reason. If I am signing this form on behalf of a person whom I have allowed to be a dependent on my insurance coverage, I acknowledge that I am personally liable for any copayment, deductible obligation, or other portion of Denton Regional's charge for services to such person that my insurance company or other third-party payer does not pay. If the patient is my minor child, I acknowledge that I am legally responsible to Denton Regional for its charges for services to the patient without regard to the allocation of liability for such charges as between other persons and me in a decree of divorce or other court order or decree. I understand that if my account with Denton Regional Urgent Care is unpaid for more than a reasonable amount of time, Denton Regional Urgent Care will place my account with a collection agency and, if necessary, cause my unpaid account to appear on my credit report. I agree to endorse and forward to Denton Regional Urgent Care all insurance or third-party payments that I receive for services Denton Regional Urgent Care has rendered to me, immediately upon my receipt of such payments.

Email: If I have provided my email address on this form, I understand that Denton Regional Urgent Care will keep that address confidential and will not rent or sell it. I understand that Denton Regional Urgent Care has requested my email address in case Denton Regional needs to contact me. I consent to Denton Regional Urgent Care's sending me, as a courtesy, 48-hour patient follow-up communications, satisfaction surveys, or urgent notices. I consent to Denton Regional Urgent Care's sending unsecured emails regarding my Denton Regional Urgent Care visit to the email address I have provided on this form.

I acknowledge that I have received or been given the opportunity to receive a copy of the HIPAA Privacy Policies and understand that if I have any questions or complaints, I should contact the Privacy Official ***_______________ (Patient/Guardian Initials)

_________________________________ _________________________

Patient / Responsible Party Date m/d/y Rev 03/14