The DOCTORS Center Urgent Care.

A Service of Southwest Medical Strategies

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Patient Information

Name _____

Address _____

City _____ State _____ Zip Code _____

Gender ❑ Male ❑ Female

Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Home Phone _____ Cell Phone _____ Pager _____

Social Security Number _____ DOB _____

Please select one of the following racial categories:

❑ Native American ❑ Black ❑ Native Hawaiian ❑ Other Polynesian ❑ White ❑ Asian ❑ Unknown

Please select on of the following ethnicity categories:

❑ Hispanic ❑ Non-Hispanic ❑ All Others / What is your preferred language? _____

Employer _____ Employer Phone Number _____

Employer Address _____

Email Address _____

Drivers License Number _____

❑ Self Pay ❑ Insurance ❑ Work Related (Date of Injury _____)

Name of Insurance _____

Policy Holder _____ DOB _____ SSN# _____

Relationship to Patient _____

Gender of Policy Holder ❑ Male ❑ Female

Policy Holders Employer and Address _____

(If Minor)

Father's Name _____ Work Number _____

Mother's Name _____ Work Number _____

Emergency Contact _____ Phone Number _____

Referred By ❑ Friend ❑ Family ❑ Advertisement ❑ Drive By ❑ Other

Patient History

Condition	Self	Family
Heart Condition	❑	❑
High Blood Pressure	❑	❑
Hepatitis, Jaundice	❑	❑
Tuberculosis	❑	❑
Pneumonia	❑	❑
Asthma	❑	❑
Diabetes	❑	❑
Arthritis	❑	❑
Thyroid	❑	❑
Anemia	❑	❑
Cancer	❑	❑
Rheumatic Fever	❑	❑
Seizures	❑	❑
Epilepsy	❑	❑
Kidney Disease	❑	❑
Stroke	❑	❑
Gall Bladder Disease	❑	❑
Osteoporosis	❑	❑

Surgeries Date

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Drug Allergies/Reactions Current Medications

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you smoke? Yes ❑ No ❑

Cigarettes ❑ Pipe ❑ Cigars ❑

_____Packs per day _____ Years

Do you drink alcohol? Yes ❑ No ❑

Coffee/Caffeine? Yes ❑ No ❑ Cups/day_____

NUECES EMERGENCY SERVICES PA, CC DOCTORS CENTER SOUTH PA, CALALLEN MINOR EMERGENCY CENTER PA ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION ("Agreement")

I hereby, direct any and all insurance carriers, attorneys, agencies, governmental, departments, companies, individuals, and/or other legal entities ("payers"), which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries or illnesses, past or future ("condition"), to pay directly to, and exclusively in the name of NUECES EMERGENCY SERVICES PA, CC DOCTORS CENTER SOUTH PA, CALALLEN MINOR EMERGENCY CENTER PA such sums as may be owning NUECES EMERGENCY SERVICES PA, CC DOCTORS CENTER SOUTH PA, CALALLEN MINOR EMERGENCY CENTER PA for charges incurred by me, including, but not limited to, charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by my at the Office ("charges"). I further grant a contractual lien to NUECES EMERGENCY SERVICES PA, CC DOCTORS CENTER SOUTH PA, CALALLEN MINOR EMERGENCY CENTER PA with respect to my charges, applicable to all payers, however I understand that nothing in this Agreement shall be construed as an election by NUECES EMERGENCY SERVICES PA, CC DOCTORS CENTER SOUTH PA, CALALLEN MINOR EMERGENCY CENTER PA to claim protection under any statutory lien law. For the purposes of this Agreement, "benefits" shall include, but shall not be limited to, proceeds from any settlement, judgment, or verdict, as well as any proceeds relation to commercial health or group insurance, disability benefits, worker's compensation benefits, medical payment benefits, personal injury protection, lost wages benefits, lost services benefits, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, malpractice proceeds, attorney retainer agreements, and any other benefits or proceeds payable to me for the purposes stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that, in the event a payer refuses to pay NUECES EMERGENCY SERVICES PA, CC DOCTORS CENTER SOUTH PA, CALALLEN MINOR EMERGENCY CENTER PA, I hereby assign to the Office, insofar as permitted by law, the following: all my rights, remedies, and benefits to NUECES EMERGENCY SERVICES PA, CC DOCTORS CENTER SOUTH PA, CALALLEN MINOR EMERGENCY CENTER PA, as well as any and all causes of action that I might have against such payer to the extent of my charges, the right to prosecute such causes of action either in my name or in the Office's name, and to settle or otherwise resolve such causes of action as the Office sees it.

IN the event that I retain one or more attorneys to represent me in this matter, I hereby direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expresses written consent of this office. I further direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any funds received by the attorney relation to my accident, to promptly pay the Office such of such funds, and to provide a full accounting to such funds to the Office upon its' request.

I hereby authorize and direct NUECES EMERGENCY SERVICES PA, CC DOCTORS CENTER SOUTH PA, CALALLEN MINOR EMERGENCY CENTER PA to file my claims with my health insurance. I understand however, that in the event that my charges are submitted in their full amount to any other form of insurance or source of payment (e.g. liability, medpay, attorneys, etc.) I hereby authorize and direct NUECES EMERGENCY SERVICES PA, CC DOCTORS CENTER SOUTH PA, CALALLEN MINOR EMERGENCY CENTER PA to collect any write-offs or discounts, issued by my health insurance, out of the proceeds from the other insurance or source of payment.

I do agree to not hold NUECES EMERGENCY SERVICES PA, CC DOCTORS CENTER SOUTH PA, CALALLEN MINOR EMERGENCY CENTER PA and J. Keith Rose responsible or liable for any injuries that I might sustain on and/or the NUECES EMERGENCY SERVICES PA, CC DOCTORS CENTER SOUTH PA, CALALLEN MINOR EMERGENCY CENTER PA facility premises. I do understand that there are risks of injury present both within the NUECES EMERGENCY SERVICES PA. CC DOCTORS CENTER SOUTH PA, CALALLEN MINOR EMERGENCY CENTER PA facilities, as well as with the treatment program itself I agree to hold NUECES EMERGENCY SERVICES PA, CC DOCTORS CENTER SOUTH PA, CALALLEN MINOR EMERGENCY CENTER PA and J. Keith Rose devoid of any liability from either unintentional or intentional acts and agree to not file any claims against NUECES EMERGENCY SERVICES PA, CC DOCTORS CENTER SOUTH PA, CALALLEN MINOR EMERGENCY CENTER PA, J. Keith Rose or employees of NUECES EMERGENCY SERVICES PA, CC DOCTORS CENTER SOUTH PA, CALALLEN MINOR EMERGENCY CENTER PA with respect to injuries sustained at NUECES EMERGENCY SERVICES PA, CC DOCTORS CENTER SOUTH PA, CALALLEN MINOR EMERGENCY CENTER PA facilities and property.

I hereby direct all payers to release NUECES EMERGENCY SERVICES PA, CC DOCTORS CENTER SOUTH PA, CALALLEN MINOR EMERGENCY CENTER PA any pertinent information regarding any coverage I may have including, but not limited to the amount of the coverage, the amount paid this far, and the amount of any outstanding claims. I authorize this Office to release any information regarding my treatment to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this Office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize NUECES EMERGENCY SERVICES PA, CC DOCTORS CENTER SOUTH PA, CALALLEN MINOR EMERGENCY CENTER PA to endorse/sign my name on any and all checks listings me as a payee which are presented to this Office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize NUECES EMERGENCY SERVICES PA, CC DOCTORS CENTER SOUTH PA, CALALLEN MINOR EMERGENCY CENTER PA to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due NUECES EMERGENCY SERVICES PA, CC DOCTORS CENTER SOUTH PA, CALALLEN MINOR EMERGENCY CENTER PA for their services. This Agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services as its' option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse NUECES EMERGENCY SERVICES PA, CC DOCTORS CENTER SOUTH PA, CALALLEN MINOR EMERGENCY CENTER PA for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Agreement shall not be modified or revoked without the mutual written consent of NUECES EMERGENCY SERVICES PA, CC DOCTORS CENTER SOUTH PA, CALALLEN MINOR EMERGENCY CENTER PA and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Agreement.

I agree that each and every provision for this Agreement is reasonably necessary for the protection of the rights and interests of NUECES EMERGENCY SERVICES PA, CC DOCTORS CENTER SOUTH PA, CALALLEN MINOR EMERGENCY CENTER PA and myself. However, should any provision of this Agreement be found to be invalid, illegal, or unenforceable or for any reason cease to be binding on any party hereto, all other provisions of this Agreement shall, nevertheless, remain in full force and effect.

Patient Signature: _____ Date: _____ /_____/_____

Patient Name (Please Print): _____

Name of Custodial Parent or Legal Guardian (please print): _____

Parent/Guardian's Signature: _____ Date: _____ /_____/_____