Your Family Walk-In Clinic
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17929 Hunting Bow Circle, Lutz, FL 33558

GENERAL INTAKE CONSENT AND HIPAA FORM

NAME_____TODAY'S DATE_____

SOCIAL SECURITY #_____ DATE OF BIRTH_____

HOME ADDRESS_____ City _____ State _____ Zip_____

PHONE NUMBER_____**EMAIL (REQUIRED)**_____

EMERGENCY CONTACT

NAME_____ RELATIONSHIP_____

ADDRESS_____TELEPHONE NUMBER_____

INSURANCE TYPE: _____ SELF PAY ☐

POLICY HOLDER SOCIAL SECURITY #_____DATE OF BIRTH_____

PHARMACY INFORMATION

NAME_____ADDRESS_____ZIP_____PHONE_____

PRIMARY CARE PROVIDER NAME: _____ PHONE #: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient: We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledge, if you wish. I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Print Name: _____ Signature: _____ Date: _____

CONSENT TO TREATMENT:

I, the undersigned, consent to and authorize the health care professionals who may be involved in my care to provide such examinations, diagnosis, care and treatment considered necessary or advisable by my healthcare providers.

GUARANTEE OF PAYMENT AND ASSIGNMENT OF INSURANCE BENEFITS:

I, the undersigned certifies that services provided at Your Family Walk-In Clinic may be submitted on my behalf as a courtesy to my insurance benefits. I understand that I am financially responsible for my co-payment, charges not paid by insurance and for non-covered services for which it is determined I was out of network or ineligible to receive. Payment in full is expected at time of service including copays, co-insurance and deductibles as determined by your insurance carrier. Outstanding balance will be charged to card on file. Payments made by check or electronic debit that fail to clear are subject to a service charge of $30.00. If collections are required the undersigned agrees to pay all costs of collection, and attorney's fees. Any fraudulent claims knowingly committed are punishable under Florida statute s. 817.234. I also authorize my provider to release all information necessary to secure the payment of benefits and to use or disclose my health information to carry out treatment, payment, or health care operations.

I have read, understand, and agree to each of the statements contained in this document.

SIGNATURE_____ **DATE**_____

RELATIONSHIP (IF OTHER THAN SELF)_____