

20 Mile Urgent Care & Family Medicine
11355 S. Parker Road, Ste 103
Parker, CO 80134 (720-974-7210)

Please Print and Complete

Today's Date: _____ Reason for Visit _____

Patient Information:

First Name _____ MI _____ Last Name _____ Nickname _____

Address _____ Apt# _____ City _____ State _____ Zip _____

Mailing Address (if different) _____

Home Phone _____ Cell Phone _____ Email _____

Date of Birth ____/____/____ Age _____ Social Security # _____ - _____ - _____ Sex _____ Marital Status _____

Primary Insurance: _____ Member ID # _____ Group # _____

Claims Address _____ City _____ State _____ ZIP _____

Secondary Insurance: _____ Member ID # _____ Group # _____

Claims Address _____ City _____ State _____ Zip _____

Primary Person to Insurance: Name _____ Date of Birth ____/____/____

Social Security # _____ Relationship _____

Financially Responsible Party: (If different from patient) Name _____ Date of Birth ____/____/____

Address _____ Apt# _____ City _____ State _____ Zip _____

Home Phone _____ Relationship _____

Contact:

			Emergency Contact?		HIPAA Contact?	
Name	Number	Relationship	Y	N	Y	N
_____	_____	_____	Y	N	Y	N
_____	_____	_____	Y	N	Y	N

Pharmacy: Name _____ Cross Streets _____

Consents:

I give authorization to release any medical information necessary to process this and any future claims, and authorize payment of medical benefits for all physician services or supplies to be made to 20 Mile Urgent Care and Family Medicine.

X _____
Signature (Patient or Authorized Person) _____ Date _____

I hereby acknowledge that I have been given the opportunity to review the privacy practices of 20 Mile Urgent Care and Family Medicine.

X _____
Signature (Patient or Authorized Person) _____ Date _____

Consent for Treatment of Minors: I understand that a minor child (17 and under) must have my consent to be treated at 20 Mile Urgent Care & Family Medicine. I understand that I must be present at each appointment for any child age 14 or younger. I also understand that Colorado Law provides minors to seek care without parental consent for certain issues.

X _____
Signature of Parent or Guardian _____ Date _____

20 Mile Urgent Care & Family Medicine

Financial Policies

Patient Name _____ Date of Birth _____

We participate with most insurance plans. With several we have a dual contract being both Family Medicine and Urgent Care. It is your responsibility to check with your insurance to verify your plan participation with our clinic. We will help you in any reasonable way to collect from your insurance carrier, HOWEVER THE ULTIMATE OBLIGATION FOR PAYMENT FOR SERVICES RESTS WITH YOU OR YOUR RESPONSIBLE PARTY.

Financial Responsibilities

We require that you provide us with copies of a photo ID and your current insurance card at every visit. If we cannot verify your insurance eligibility with the information you provide, payment in full is expected at the time of your visit.

Co-Payments are collected at the time services are rendered. Any outstanding balance from deductibles, co-insurance, etc. are due in full upon receipt of your statement.

Referrals

It is your responsibility to know your insurance requirements. If your insurance requires that you obtain a referral for a visit other than at your primary care provider's office, then it is your responsibility to obtain that referral.

Self-Pay

We offer services for non-insured patients; however, the reception staff is unable to quote prices for these services. Our basic office visit begins at \$125. Any additional charges resulting from additional testing or procedures will be discussed with you before they are performed. All charges are payable and expected at time services are rendered. No checks are accepted for self-Pay.

Collection Fees

If we must employ a collection agency to collect on any unpaid balances, you will be responsible for any collection fees, court costs and other reasonable collection expenses.

Returned Check Fees

There will be a charge of \$30 for any check that is not honored by your bank. This overdraft could also prevent us from accepting checks from you in the future.

I have read and understand the above financial policies.

X _____
Signature

Date