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

Name_____Number_____Relationship_____ 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 $150. Any additional charges resulting from additional testing or procedures will be disussed with you before they are performed. All charges are payable and expected at time services are rendered. No checks 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