Urgent Care Center
MEDSTOP
Madonna Plaza SLO

283 Madonna Road, Suite B, San Luis Obispo, CA 93405
(805) 549-8880 FAX (805) 783-2009

FOR OFFICE USE ONLY
TIME: _____ / _____

Prep: _____
Exit review: _____
Breakdown: _____

PATIENT INFORMATION SHEET

PRINT CLEARLY

LAST NAME FIRST	DATE OF BIRTH	AGE	GENDER M F
MAILING ADDRESS	CITY STATE		ZIP CODE
STREET ADDRESS	CITY STATE		ZIP CODE

HOME PHONE	CELL PHONE	SOCIAL SECURITY#	MARITAL STATUS S M D W
EMAIL ADDRESS			
OCCUPATION	EMPLOYER NAME	EMERGENCY CONTACT NAME	PHONE NUMBER

RESPONSIBLE PARTY BILLING INFORMATION

RESPONSIBLE PERSON	RELATION TO PATIENT	DATE OF BIRTH	DAYTIME PHONE

INSURANCE (Present Insurance card for verification of coverage)

NAME OF INSURANCE	NAME OF INSURED (if not SELF)	DATE OF BIRTH	RELATION TO PATIENT

MEDSTOP URGENT CARE CENTER is authorized to release/discuss information regarding my medical care to persons listed below:

PRINT NAME PHONE NUMBER

_____ _____

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL WITHDRAWN, BY THE PATIENT, IN WRITING.

·Release of Information · Assignment of Benefits ·Notice of Privacy ·Acceptance of Financial Responsibility

- **I authorize the release of medical information** to my primary care physician as identified in my medical records and/or to any physician to whom I may be referred.
- **I authorize direct payment of medical benefits** to MEDSTOP URGENT CARE CENTER and the release of my medical information or other information necessary to process this claim, to my insurance company.
- **I have received a copy** of the MEDSTOP URGENT CARE CENTER Notice of Privacy Practices.
- **I understand that I am ultimately responsible for payment** of charges, regardless of my insurance status, including responsibility for co-payment, deductible, amounts above allowable and non-covered/denied services. We are not contracted with MediCal/CenCal or any State based Medicaid programs.
- **CONSENT FOR TREATMENT**
  Consent is hereby given to MEDSTOP URGENT CARE CENTER and the treating practioner to administer such treatment and to perform such medical and/or surgical procedures as they deem necessary.

Patient Signature _____ Date _____
(Indicate relation to patient, if not SELF)

REVISED 6/10/20 km