

Visit ID \_\_\_\_\_  
Pharmacy \_\_\_\_\_

Copay \$ \_\_\_\_\_



**Thank you for choosing MainStreet Family Urgent Care!**

**IS TODAY'S VISIT WORK RELATED? IF YES – PLEASE LET THE FRONT DESK KNOW**

Patient Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_-\_\_\_\_-\_\_\_\_ Gender: M / F  
Mailing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Email: \_\_\_\_\_ Cell Phone \_\_\_\_\_  
**Primary Care Doctor:** \_\_\_\_\_ **Chief Complaint:** \_\_\_\_\_  
**Best Phone Number to Reach You:** \_\_\_\_\_ Cell or Home or Work (circle one)

**Emergency Contact:**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_-\_\_\_\_-\_\_\_\_ Relationship: \_\_\_\_\_

**Primary Insurance Policy Holder / Party Responsible for Payment if DIFFERENT from information above:**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: M / F Social Security Number: \_\_\_\_\_-\_\_\_\_-\_\_\_\_

**Responsible Party Address, Phone, and Email if DIFFERENT from above**

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**I authorize Rural Urgent Care LLC/MainStreet Family Urgent Care to release my Private Health Information to the individuals below (please list):**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

**How Did You Hear About Us (Circle One)?**

Drive By/Saw Sign Event Facebook Friend/Family Internet Search Mail Radio Other \_\_\_\_\_

### **Privacy, Billing, and Other Important Information**

I authorize Rural Urgent Care LLC/MainStreet Family Urgent Care to contact me: (1) at the number(s) listed above and leave a voicemail if I am unavailable; (2) send text messages to phone number(s) listed above; (3) send email messages to email(s) listed above. I have read and reviewed Rural Urgent Care LLC/MainStreet Family Urgent Care's Billing Policies and Privacy Policy. We will file a claim with your insurance company for the services provided, in the event of non-payment you will be responsible the charges incurred today. I authorize release of any information concerning my (or my child's) health care and treatment for the purpose of evaluating and administering claims of insurance benefit. I authorize Rural Urgent Care LLC/MainStreet Family Urgent Care to charge my credit card for charges allowed, but not paid for, by my insurance company (patient responsibility). I hereby authorize payment of insurance benefits, otherwise payable directly to me, to the Provider who has assigned those to Rural Urgent Care LLC/MainStreet Family Urgent Care. I consent to care and treatment of myself (or my child) by the attending provider and his/her associates and assistants.

X \_\_\_\_\_  
(Signature of patient or parent/guardian of minor)

**Date:** \_\_\_\_\_