



760 S. Colorado Blvd, Unit A
 Denver, CO 80246
 Phone 303-692-8000 | Fax: 303-300-6685
 Monday - Friday 8:00am-8:00pm
 Saturday & Sunday 8:00am-6:00pm

Patient Registration Form

Please fill out completely.

Patient Full Name: _____ Sex: ___ Male ___ Female
 Date of Birth: _____ Age: _____ Social Security #: _____
 Street Address/Apt #: _____ Emergency Contact: _____
 City, State, Zip: _____ Emergency Phone #: _____
 Phone #: _____ Relationship to Patient: _____
 Confidential Email: _____
 Reason for Visit: _____ Best Form of Contact: ___ Phone ___ Email
 How did you hear about us?
 ___ Google, Yahoo, Bing ___ Insurance ___ School/University ___ Event/Chamber
 ___ Yelp ___ Employer ___ Hotel/Pharmacy ___ Physician Referral
 ___ Drive By ___ Existing Patient ___ Friend/Relative
 ___ Other: _____

Based on government regulations we are required to ask for the following information: ___ I prefer not to answer.

Preferred Language: _____ Race: ___ American Indian/Alaska Native ___ Asian
 Ethnicity: ___ Hispanic or Latino ___ Black/African American ___ Caucasian
 ___ Non-Hispanic or Latino ___ Native Hawaiian/Other Pacific Islander

Guarantor Information:

___ Check if same as patient information and sign by the "X" below. If not, please complete the entire section and sign.

Name: _____ Sex: ___ Male ___ Female
 Date of Birth: _____ Social Security #: _____
 Street Address/Apt #: _____ Phone #: _____
 City, State, Zip: _____ Email: _____

I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office is due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefits to this office. In the event that my account is turned over to a collection agency, I agree to pay all late fees, costs of collection fees, and/or attorney fees and all court costs, if any.

X: _____ Date: _____
 Patient or Guarantor Signature (If patient is a minor)

Consent For Treatment: I, the undersigned consent to the care and treatment by the attending physician and/or his or her associates or assistants. I acknowledge that no guarantees have been made as to the effect of such treatment.

X: _____ Date: _____
 Patient or Guarantor Signature (If patient is a minor)

Notice of Privacy Practices: I, the undersigned have reviewed the AFC Urgent Care Notice of Privacy Practices and understand that I may request a copy of the policy at any time.

X: _____ Date: _____
 Patient or Guarantor Signature (If patient is a minor)



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Important Information!

Do not sign if you do not fully understand the policies. We are happy to explain the process if you have questions.

AFC Urgent Care Denver requires all patients or patient’s guarantor to link an H.S.A., credit card, or debit card with their patient profile. We can offer you two options:

- 1.) Allow us to place a card of your choice on file. If you have a balance on your account after insurance processes your claim the card on file will be ran for the full balance due. You do have the option of setting up a payment plan as well as removing your card on file after ALL charges have been paid.
- 2.) If you choose to not place a card on file, we will need to collect a \$140 deposit today in addition to your copay or deductible deposit. This amount will be applied to your outstanding balance after insurance processes your claim. In the event your insurance covers your visit, please contact the clinic to initiate the refund process.

This information is required prior to being treated. We will not be able to provide treatment without this payment information.

This policy does not apply to patients with Medicaid

I hereby authorize AFC Urgent Care Denver to charge my account for any deductible, coinsurance, copay, or non-covered services following receipt of my insurance carrier’s explanation of benefits. Furthermore, I understand that should my card not process successfully I may incur late charges, finance charges, and collections fees. If you have any questions, please call billing Monday through Friday from 8am to 4pm at 303-782-1111.

 Print Patient Name

 Date

 Signature of patient or parent or guarantor

 Name as it appears on card

Narcotics Policy Acknowledgement

We do not fill/refill DEA controlled substances such as narcotics, ADHD, or Anxiety medications. Please consult your specialist for further management. Thank you for your cooperation.

I have read and agree to comply with the above statement regarding the Narcotics Policy for AFC Urgent Care.

Sign: _____ Date: _____
Patient or Guarantor Signature (If patient is a minor)

Medical Photography Consent

I _____ understand that digital image recordings may be made and recorded of me. I understand the term “medical images” as used here includes electronic as well as printed images. I understand and agree that the nature of use of these images is for purposes of medical records, consultation, and teaching. Although measures will be taken to reduce or eliminate identifying features, the possibility remains that someone may recognize me.

The use of medical images for consultation purposes includes sharing of these images with other healthcare providers who are involved in the diagnosis and treatment of my conditions. The use of medical images for teaching purposes includes the use of my images for teaching medical students, medical residents, practicing physicians, and other healthcare professionals.

I have been provided the opportunity to ask questions concerning medical photography and understand that refusal to consent will not affect my medical care.

____ I consent to allow medical photographs for all purposes described above.
 ____ I do not provide consent to allow recording or saving of medical photographs.

Sign: _____ Print: _____ Date: _____
 Patient or Guarantor Signature (If patient is a minor)

Staff Print: _____ Staff Sign: _____ Date: _____

****ALL signatures on this page are valid for one year from signing date and correlate to all visits within that year.****