3800 Irving Street
Denver, CO 80211
Phone 303-477-6000 I Fax: 303-975-6629
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)

3800 Irving Street
Denver, CO 80211
Phone 303-477-6000 I Fax: 303-975-6629
Monday - Friday 8:00am-8:00pm
Saturday & Sunday 8:00am-6:00pm

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 (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.****