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

Patient Registration Form

Is today's visit work related? If yes, do not complete this form. Please see the front desk staff for instructions.

Patient Full Name: _____ Sex: ____Male ___Female
Date of Birth: _____ Age: _____ Social Security #: _____
Mailing Address: _____ Apt #: _____ Gender ID: _____
City, State, Zip: _____ Emergency Contact: _____
Phone #: _____ Emergency 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

Insurance Information (if no physical card):

Primary Ins : _____ ID #: _____
Policy Holder: _____
Date of Birth: _____
Relationship to Patient: _____

Secondary Ins: _____ ID #: _____
Policy Holder: _____
Date of Birth: _____
Relationship to Patient: _____

Financial Responsibility/Assignment of Benefits:

___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 #: _____
Phone #: _____ 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. I agree to be contacted at any telephone number or email address associated with my account. This includes cellular telephone numbers or other wireless devices. I understand this could result in a charge from my phone or device carrier to me for talk time, SMS messaging/texts or data usage for emails or voice mails. I also understand methods of contact may include pre-recorded /artificial voice messages and/or the use of automatic dialing devices as applicable.

X:_____ **Date:** _____
Signature of Patient or Guardian

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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:** _____

Signature of Patient or Guardian

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:** _____

Signature of Patient or Guardian

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

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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:** _____

Signature of Patient or Guardian

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