

Patient Information
Insurance

University Walk in Medical Center
11550 University Blvd.
Orlando, Fl 32817
(407) 282-2044

Patient	Last Name		Date of Birth		Sex	Home Phone #	
	First Name M.I.		Social Security# <i>(required if over 18)</i>			Cell Phone #	
	Street Address		Apt #	City	State	Zip	Marital Status
	Employer <i>Or</i> College Name		City	State	Zip	Work Phone #	
	Primary Care Physician			City	State	Phone #	

Responsible Party <small>(who receive's bills / refunds)</small>	Last Name		Date of Birth		Sex	Home Phone #	
	First Name M.I.		Social Security # (required)			Cell Phone #	
	Street Address		Apt #	City	State	Zip	Marital Status
	Employer Name		City	State	Zip	Work Phone #	

Insurance	Primary Insurance Company		Subscriber ID / Policy #			Group #	
	Subscriber's <u>FULL</u> Name		Date of Birth (required)		Employer	Relationship to Patient	
	Subscriber's Street Address		Apt #	City	State	Zip	
	Secondary Insurance Company		Subscriber ID / Policy #			Group #	
	Subscriber's <u>FULL</u> Name		Date of Birth (required)		Employer	Relationship to Patient	

Are you interested in information about Living Wills? *(circle answer)*

a. Not at this time b. Yes, provide me info c. I currently have one (please provide copy to our office)

Over 18	I would like to designate the following person as authorized to discuss my Personal Health Information, including diagnosis and treatment plans, with the UWMC office staff. This authorization remains in force until further written notice from the patient.		
	Authorized Persons <u>Full</u> Name	Authorized Persons BirthDate	Relationship to Patient

I authorize the physician to administer treatment, as he/she deems advisable for my diagnosis and treatment. I understand that these services are voluntary and I have the right to refuse them.

Patient and/or guardian are responsible for charges incurred. It is a courtesy for our office to file your health insurance. You are responsible for your copay/coinsurance that your insurance deems you liable for on the day of your visit. The amount paid by you on the date of visit is an estimation of your out of pocket expense. The final cost determination will be made by your insurance company once the claim is processed. In the event your insurance has denied your claim you are responsible for the balance due within 60 days of the first bill. Unpaid balances will be forwarded for further collection action at which time there will be an additional \$20 late fee added to the balance due.

A copy of our "Notice of Privacy Practices" is posted in our lobby. This notice informs you how we may use and/or disclose your health information. You may request a personal copy of this notice at any time from our staff.

By signing below you are acknowledging the above policies and procedures. This acknowledgement will be in force upon signature. This acknowledgement will remain in force until UWMC receives written notification from the patient revoking it.

Patient or Guardian Signature	Patient or Guardian Printed Name	Date
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