

Cornerstone Pediatric Urgent Care

1430 N Cooper Rd, Ste 101 • Gilbert, AZ 85233 • 480.633.1111 • www.mysickkid.com

(Revised 11/09)

PATIENT INFORMATION				
LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH	SEX MALE ____ FEMALE ____
PARENT/LEGAL GUARDIAN INFORMATION				
LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH	SOCIAL SECURITY # - -
RELATIONSHIP TO PATIENT	DRIVER LICENSE NUMBER	STATE	HOME PHONE ()	CELL PHONE ()
ADDRESS (STREET AND APT)		CITY	STATE	ZIP
EMAIL ADDRESS		EMPLOYER		WORK PHONE ()
PATIENT'S INSURANCE INFORMATION - Please present insurance card(s) to the receptionist				
PRIMARY INSURANCE NAME		SECONDARY INSURANCE NAME		
Is the parent/guardian listed above the primary insured (circle one)? YES NO (If Yes, skip to the next section)				
PRIMARY INSURED LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH	SOCIAL SECURITY # - -
RELATIONSHIP TO PATIENT	DRIVER LICENSE NUMBER	STATE	HOME PHONE ()	CELL PHONE ()
ADDRESS (STREET AND APT)		CITY	STATE	ZIP
PRIMARY CARE PHYSICIAN INFORMATION				
NAME	PRACTICE NAME	PHONE ()	FAX (If known) ()	
HOW DID YOU HEAR ABOUT US?				
<input type="checkbox"/> PCP Referral <input type="checkbox"/> Internet <input type="checkbox"/> Friend <input type="checkbox"/> Drive-by/walk-by <input type="checkbox"/> Magnets <input type="checkbox"/> Magazine _____ <input type="checkbox"/> Other urgent care <input type="checkbox"/> Other _____				
EMERGENCY CONTACT INFO - Someone who does NOT live with you but can reach you				
LAST NAME	FIRST NAME	RELATIONSHIP	HOME PHONE ()	CELL PHONE ()
ADDRESS (STREET AND APT)		CITY	STATE	ZIP

Assignment of Benefits: In the event the patient, his/her authorized representative or the guarantor signing below, is entitled to benefits of any type arising out of any policy of insurance insuring the patient or any other party liable for the patient, those benefits are hereby assigned to Cornerstone Pediatric Urgent Care for application to the patient's bill. Such payment shall discharge the insurance company of any obligation under the policy to the extent that the payment has been made accordingly to the terms of the policy. The undersigned shall remain responsible for any and all charges not paid by the insurance company and/or covered by this assignment. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable for this patient, is hereby assigned to Cornerstone Pediatric Urgent Care.

Parent/Guardian Signature: _____ Date: _____

Financial Responsibility: I agree that in return for the services provided to the patient by Cornerstone Pediatric Urgent Care and/or any assisting physicians or providers, I will pay the account of the patient prior to discharge or make financial arrangements satisfactory to Cornerstone Pediatric Urgent Care. In the event of default, I agree to pay all costs of collections, and reasonable attorney's fees. A delinquent account (60 days from date of service) will be charged a \$10.00 billing fee and may be charged interest at the legal rate.

IT IS UNDERSTOOD THAT THERE MAY BE AN ADDITIONAL CHARGE FOR X-RAY OR LABORATORY TESTS PERFORMED BY PROVIDERS OF ORGANIZATIONS OTHER THAN CORNERSTONE PEDIATRIC URGENT CARE THAT WILL BE BILLED SEPARATELY.

Parent/Guardian Signature: _____ Date: _____

Consent To Treat And/Or Release: I hereby authorize Cornerstone Pediatric Urgent Care and its providers to examine and treat me and/or my child when necessary. I also authorize the release of my/our protected health information (PHI), acquired in the course of examination to carry out treatment, payment and healthcare operations (TPO) on our behalf.

Parent/Guardian Signature: _____ Date: _____