



University Walk-In Medical Center, Inc  
 11550 University Blvd  
 Orlando, FL 32817  
 407-282-2044

Patient Information  
 Insurance

<b>PATIENT</b>	Last Name		Date of Birth		Sex	Home Phone #		
	First Name	MI	Social Security # (required if over 18)			Cell Phone #		
	Street Address		Apt #	City		State	Zip	Marital Status
	Employer or College Name		City	State		Zip	Work Phone #	
	Primary Care Physician			City		State	Phone #	

<b>PATIENT</b> <small>(who receives bill / refunds)</small>	Last Name		Date of Birth		Sex	Home Phone #		
	First Name	MI	Social Security # (required)			Cell Phone #		
	Street Address		Apt #	City		State	Zip	Marital Status
	Employer or College Name		City	State		Zip	Work Phone #	

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

<b>OVER18</b>	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 authorized 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 60days of the first bill. Unpaid balances will be forwarded for further collection action at which time there will be additional \$20 late fee added to the balance due.

A copy of our "Notice of Privacy Practices" is posted on 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.

Parent or Guardian Signature	Patient or Guardian Printed Name	Date
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