



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

Patient Information
 Self Pay

PATIENT	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 #	
	Primary Care Physician				City	State	Phone #	

RESPONSIBLE PARTY <small>(who receives bills / 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 #	

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 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 or Guardian is responsible for all charges incurred on the day of the visit.

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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