MAIN STREET
Urgent Care
A Minor Emergency Clinic

1421 S. Main St. Suite #111, Boerne TX, 78006
Phone: (830) 249-9995 Fax: (830) 249-9868
1426 E. Main St., Suite #300 Fredericksburg TX, 78624
Phone: (830) 997-9995

PATIENT INFORMATION

Date of Birth ____ / ____ / ____ Age _____

Last Name: _____

First Name: _____ MI: ___

Social Security Number (Last 4): _____ Sex ☐ M ☐ F

Race:

☐ Black ☐ Asian ☐ White
☐ Native American or Alaska Native ☐ Native Hawaiian or Pacific Islander

Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Preferred Language: _____

Today's Date: _____ / _____ / _____

Address: _____ Apt: ____

City: _____ State: ___ Zip: _____

Email: _____

Home Phone: _____ Cell Phone: _____

Preferred Contact: Home Cell (Circle One)

Primary Care Provider (PCP): _____

Emergency Contact Name: _____

Phone: ( ) ___ - _____ Relation: _____

PARENT / GUARANTOR INFORMATION

Name (Last, First, MI): _____

Date of Birth: _____ / _____ /_____ Social Security Number (Last 4): _____ Sex ☐ M ☐ F

Address: _____ Apt: ____ City: _____ State: ____ Zip: _____

Home Phone: ( ) ___ - _____ Cell Phone: ( ) ___ - _____ Email: _____

Relationship to Patient: ☐ Parent ☐ Guardian ☐ Legal Guardian ☐ Authorized Party (*see back of registration*)

PRIMARY INSURANCE

Policy Holder Name: _____ Date of Birth: ___ / ___ / ___ Sex M F

Member ID: _____ Group Number: _____ ☐ ☐

Address: _____ Apt: ____ City: _____ State: ___ Zip: _____

Relationship to Patient: ☐ Parent ☐ Guardian ☐ Spouse ☐ Legal Guardian ☐ Authorized Party (*see back of registration*)

SECONDARY INSURANCE

Policy Holder Name: _____ Date of Birth: ___ / ___ / ___ Sex M F

Member ID: _____ Group Number: _____ ☐ ☐

Address: _____ Apt: ____ City: _____ State: ___ Zip: _____

Relationship to Patient: ☐ Parent ☐ Guardian ☐ Spouse ☐ Legal Guardian ☐ Authorized Party (*see back of registration*)

HOW DID YOU HEAR ABOUT US?

☐ Doctor Referral: _____ ☐ Internet ☐ Previous Visit

☐ Newspaper Ad ☐ Drive by / Street Sign ☐ Other: _____

☐ Friend Referral ☐ School Function or Program

Notice of Privacy Practices Your name and signature below indicated that you have read, understand, and agree to

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Quality Acute Care, PA/Main Street Urgent Care's (hereafter referred to as "MSUC") Notice of Privacy Practices. If you have any questions regarding the information in Quality Acute Care, PA/MSUC's Notice of Privacy Practices, contact our Privacy Officer at (830) 249-9995.

Name (please print): _____
Signature of Patient / Guardian: _____
Date: ____ / ____ / ____

Medical Care/Treatment Financial Policy

You will be responsible for either full payment or payment as indicated by your insurance plan.

If you have insurance:

If Quality Acute Care, PA/MSUC has a contract with your insurance company we file today's charges with that insurance company. You will be responsible today for your co-payment, coinsurance and/or the cost of any services not covered by insurance. You may receive a bill from Quality Acute Care, PA/MSUC for any unpaid balance.

If you do not have insurance:

If you do not have insurance coverage or Quality Acute Care, PA/MSUC does not have a direct contract with your insurance company, you will be required to pay in full for your visit today. You can expect to pay an initial payment for medical care/treatment based on current Fee for Service (FFS) price list, which will be collected at check-in.
If your treatment requires more complex evaluations, lab tests, vaccines, medications, X-rays, or supplies, you will be charged for those in addition to the appropriate office visit fee. These fees will be collected after service and treatment have been provided.

Release of Medical Records, Assignment of Benefits, Financial Responsibility

I authorize Quality Acute Care, PA/MSUC to submit claims to my insurance carrier as well as medical records needed to evaluate these claims for payment. I further authorize payment of benefits, otherwise payable to me, to be made payable to Quality Acute Care, PA/MSUC. I understand that I am financially responsible for all charges not covered by my insurance.
If my insurance company is not in Quality Acute Care, PA/MSUC's network or I have no insurance coverage, I understand that I am financially responsible for all charges and must make full payment today.

Signature of Patient / Guardian: _____
Date: ____ / ____ / ____

Consent for Medical Treatment

I give permission to Quality Acute Care, PA/MSUC to perform the medical and surgical processes, treatment, and/or procedures that the physician and other non-physician providers and assistants may deem to be necessary. In addition, I authorize Quality Acute Care, PA/MSUC to release any information obtained during the course of my examination and/or treatment to my healthcare insurer or other payer.

Signature of Patient / Guardian: _____
Date: ____ / ____ / ____

Authorized Party (*if applicable*)

I hereby certify that I have authorization to represent the patient in regards to medical care and treatment.

Parent's Name: _____
Parent's Phone Number: _____
Authorized Party Signature: _____
Date: ____ / ____ / ____