



PATIENT NAME _____ DATE ____/____/____ TIME _____
PATIENT BIRTHDATE ____/____/____ SSN# _____
GUARDIAN (If patient is a minor) _____ PRIMARY CARE PHYSICIAN _____
REASON FOR TODAY'S VISIT? _____ / _____
CURRENT MEDICATIONS (include over the counter) 1 _____ 2 _____
3 _____ 4 _____ 5 _____ 6 _____

NEW PATIENTS – PLEASE CONTINUE

ADDRESS _____
CITY/STATE _____ ZIP CODE _____
HOME PHONE _____ WORK PHONE _____ EMPLOYER _____
MAY WE CALL YOU AT HOME? _____ WORK? _____ MAY WE LEAVE A MESSAGE? _____
INSURED'S NAME (IF NOT PATIENT) _____ SSN# _____
INSURED'S BIRTHDATE (IF NOT PATIENT) ____/____/____ RELATIONSHIP TO PATIENT _____
PLEASE TELL US HOW YOU HEARD ABOUT US _____

CONSENT TO FILE INSURANCE/FINANCIAL RESPONSIBILITY

Your medical health coverage is a contract between you and your insurance company. Tryon Urgent Care will file **"In Network"** medical insurance claims. In network insurance company co-payments and deductibles are due at time of service.

Our facility insurance claims are serviced by Pioneer Medical Billing LLC. Lab Work processed outside of Tryon Urgent Care will be serviced and billed separately by Spectrum Laboratories.

Patients with **"Out of Network"** insurance are responsible for payment in full at time of service. A Billing statement will be prepared for you to file with your insurance company.

By my signature below, I give my consent to Tryon Urgent Care to file a medical claim to my carrier. I understand that all unpaid charges are my responsibility. If you have any questions please feel free to ask the receptionist.

Signature of Patient or Legal Guardian

A 10% discount is offered to patients paying in full with cash, check, credit, or debit cards.