Patient Information

Name: _____

Address :_____

City: _____**State:** _____ **Zip:** _____

Home: (_____**)** _____

Cell: (_____**)** _____

Work: (_____**)** _____

SSN: _____ **-** _____**-** _____ **DOB:** _____

Age: _____ **Gender:** ☐ **M** ☐ **F**

Emergency Contact Relationship: _____

Name: _____

Phone Number: (_____ **)** _____ **-** _____

Parent/Guardian/Guarantor: Please provide YOUR information if patient is UNDER 18 years of age:

Name: _____

Address: _____

City: _____**State:** _____ **Zip:** _____

Cell: (_____**)** _____

SSN: _____ **-** _____**-** _____ **DOB:** _____

Relationship to patient: _____

EMAIL: _____

How heard about us: _____

PHARMACY: _____

Insurance Information

Primary Insurance:_____

Policy Holder Information (write "same:" if same and add employer):

Name: _____

SSN: _____ **-** _____**-** _____ **DOB:** _____

Employer: _____

Relationship to patient: ☐**SELF** ☐**SPOUSE** ☐**PARENT** ☐**CHILD**

BILL MY INSURANCE AS: URGENT CARE or PRIMARY CARE
(please circle one)

Secondary Insurance: _____

Policy Holder Information (write "same:" if same and add employer):

Name: _____

SSN: _____ **-** _____**-** _____ **DOB:** _____

Employer: _____

Relationship to patient: ☐**SELF** ☐**SPOUSE** ☐**PARENT** ☐**CHILD**

I hereby authorize Walk-In Medical Care to release my records to _____(**family**).

I hereby authorize Walk-in Medical Care to check eligibility on my behalf for covered services rendered by them. I authorize the release of any necessary information, including medical information, to my insurance carrier. ***I understand and agree to be responsible for any portion of this claim that for any reason is not covered by my insurance and understand that it is my responsibility to make sure that my medical visits are paid in full.*** _____. ***(responsible party's initials)***

Patient agrees to reimburse WIMC the fees of any collection agency if debt is not paid more than 120 days after the first statement is sent, which is a percentage of 35% of the debt owed, and all costs and expenses we incur in such collection efforts, as well as any service charges assessed to accounts with returned checks. I further consent that I authorize to be treated by the physicians and medical staff within the Walk-In Medical Care facility. I further certify that the information I provided above is true and correct.

Patient/Guardian Signature: _____ **DATE:** _____

Patient/Guardian Printed Name: _____

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Burke - 6045 Burke Centre Parkway, Suite M Burke, VA 22015 t:703-239-0300 f:703-239-0442
Fairfax Station - 9015 Silverbrook Road, #106 Fairfax Station, VA 22039 t:703-495-9148 f:703-495-8447