We would like to thank you for choosing Neighborhood Urgent Care for your Health Care Needs

We are committed to providing an office environment that is professional, caring and respectful of your time and privacy. The following agreement outlines communication information and office policies that is important in providing you with the absolute best care.

DISCLOSURE CONSENT: I can ask for and receive a copy of the Notice of Privacy Practices for this office upon request. I understand that it may/will be necessary to contact me with test results, billing questions, information about referrals to other offices, or to obtain medical information which may be needed to provide me with appropriate care.

How do you wish to be contacted for billing/insurance questions & health related questions we may Have for you? :____

May we leave messages on your voice mail or answering machine? :_________________________

May we speak with a family member or leave messages for you with another person(s)? ________

If so, Name & Relationship to You: ____
Phone #:____

Alternate: Name & Relationship: ____
Phone #:____

I understand Neighborhood Urgent Care may need to disclose my protected healthcare and personal information to another entity (pharmacies, making referrals, and my insurance company) and I consent to disclose for these permitted uses, by fax or telephone.

Our Patient and Guest agreement with you is as follows:

Due to Limited Space in our office we can only allow 2 people, including children, in the back with you during your appointment.

CELL PHONES: Please – Turn off all cell phones or your ringer while in our office so that our Staff may give you undivided attention – for Privacy reasons, photographs are not to be taken out of respect for the privacy of the other patients.

I have read the agreements above and understand I will receive a copy of this notice for my records.

Patient Signature	**Date**	**Account Number**

Signature of Parent/Guardian if Patient is a Minor