

Family Care NOW

an affiliate of ALLIANCE COMMUNITY HOSPITAL 

Urgent Care Center: Family Care NOW
 506 W. Main Street
 Louisville, OH 44641
 330-875-5625
 Fax: 330-875-5723

_____ Date of Birth _____
 Last Name First Name Middle Name

Address _____ City _____ State _____ Zip code _____

Home Phone # _____ / _____ / _____ Cell Phone # _____ / _____ / _____ Pharmacy _____

Social Security # _____ / _____ / _____ Sex (please circle) **M** **F**

Marital Status: (please circle) Married Widowed Divorced Single Separated

Guardian/ or Responsible Party _____ Phone: _____ / _____ / _____

_____ Last Name First Name Middle Initial
 Address (if different than above) _____
 Street City State Zip code

Primary Insurance _____ **Member I.D. #** _____ **Group #** _____

Policyholder Name _____ **Date of Birth** _____ **SS #** _____

Policyholder employer _____ **Phone #** _____ / _____ / _____

Patient's Relationship to Policyholder (check one) **Self** **Spouse** **Dependent**

Secondary Insurance Name _____ **Member I.D. #** _____ **Group #** _____

Policyholder Name _____ **Date of Birth** _____ **SS #** _____

Policyholder employer _____ **Phone #** _____ / _____ / _____

Patient's Relationship to Policyholder (check one) **Self** **Spouse** **Dependent**

Please give the name and phone number of a responsible person that you give permission for our office to contact in case of an emergency, to give test results, or other medical information.

1. _____
 Name Relationship Phone #

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 Name Relationship Phone #

I am authorizing treatment for the above patient. This treatment may include administration of medications, diagnostic testing and X-ray examinations, or other treatment as deemed necessary by the attending physician. I authorize the release of any medical or other information necessary to process claims on my behalf. I authorize my insurance benefits (including authorized Medicare benefits, if applicable) be paid directly to Family Care Now for any services furnished. I understand that I am responsible for all copays, deductibles, and co insurance. Furthermore, if I am not eligible for insurance, I am responsible for full payment of services rendered. I acknowledge that I have received the Notice of Privacy Practices of Alliance Citizens Health Association, which sets forth the ways in which my personal health information may be used and disclosed, and outlines my rights with respect to such information as well as a copy of the Patient Right's and Responsibilities.

Signature: _____ Date: _____
 Relationship if not signed by patient

May we leave a message on the answering machine or with the person answering, concerning:

Results of tests (please circle) Yes No Name of your personal physician _____