Welcome to Liberty Urgent Care of PA. In order to expedite your visit, please complete **ALL** of the information below.

<table>
<tr><td colspan="3">Patient Full Name:</td><td>Today's Date: / /</td></tr>
<tr><td>Date of Birth:
/ /</td><td>SSN:
- -</td><td>Gender:
M F T Non-binary</td><td rowspan="2">Patient/Guardian Phone Numbers:
Home: ( ) -
Cell: ( ) -</td></tr>
<tr><td colspan="3">Address:</td></tr>
<tr><td>City:</td><td colspan="2">State: ZIP:</td><td rowspan="2">Marital Status:
S M D W</td></tr>
<tr><td colspan="3">Email:</td></tr>
<tr><td>Primary Care Physician:</td><td colspan="2">PCP Phone:</td><td></td></tr>
<tr><td>PCP Address:</td><td colspan="3">City: State: ZIP:</td></tr>
<tr><td colspan="2">Emergency Contact:</td><td colspan="2">Phone:</td></tr>
<tr><td colspan="2">Pharmacy Name and City:</td><td colspan="2">How Did You Hear about Us?</td></tr>
</table>

<table>
<tr><th colspan="2">PRIMARY INSURANCE HOLDER (NAME OF SUBSCRIBER)</th></tr>
<tr><td>FULL NAME:</td><td>DOB: / /</td></tr>
<tr><td colspan="2">ADDRESS: CITY: STATE: ZIP:</td></tr>
<tr><td colspan="2">RELATION: SELF CHILD SPOUSE EMPLOYEE OTHER(SPECIFY):</td></tr>
</table>

Payment is required at the time services are rendered unless you are a member of a participating insurance plan with Liberty Urgent Care of PA. I authorize release of information regarding my (or my child's) healthcare, advice, and treatment provided for the purpose of evaluation and administering claims for insurance benefits. If Liberty Urgent Care of PA bills my health insurance on my, (or my child's) behalf, I authorize payment to be made directly to Liberty Urgent Care of PA. All co-payments and deductible will be collected at the time of service.

I understand the terms of payment and I have been given the opportunity to read this financial policy. I understand and accept that I am ultimately responsible for payment of services rendered by Liberty Urgent Care of PA. I understand that Liberty Urgent Care of PA will take any and all means to collect any outstanding debt on my account past 30 days time. I understand there is a charge of $25 for any returned personal checks due to insufficient funds.

I authorize my information to be accessed by all Liberty Urgent Care of PA facilities to provide continuity of care. This information includes any and all charting, testing, or plan of care that was provided to me during this visit.

____ DATE: ________/_________/________

SIGNATURE OF PATIENT/GUARDIAN

LIBERTY URGENT CARE