304 E. Central Avenue
LaFollette, TN 37766

Today's Date: ________________

Patient Demographics			
Name:	**DOB:**	**Age:**	**Gender:**
Mailing Address:			
City:	**State:**	**Zip:**	
Social Security #	**Home Phone:**	**Cell Phone:**	
Pharmacy:	**City:**		
Pharmacy Phone #:			
Primary Care Provider:	**Phone #:**		
Emergency Contact:	**Phone #:**	**Relation:**	
Provide insurance information if applicable, otherwise please write in SELFPAY.			
Primary Insurance:	**Secondary Insurance:**		
ID #	**ID #**		
Group #	**Group #**		
Guardian/Person responsible for payment – If Patient is under the age of 18:			
Name:	**Relation:**	**Contact #**	
Address:			
City:	**State:**	**Zip:**	

The Patient or Guarantor is responsible for payment in full of all services rendered by the health provider or employees of Jacksboro Urgent Care, LLC. Payment is expected at the time of service unless other arrangements are made in advance.

Authorization, Assignment, and Responsibility of Account

I hereby authorize Renovation Health and Wellness, LLC to release the above insurance companies and/or carriers any medical or other information needed for claims reimbursement. I hereby assign, transfer, and set over to Renovation Health and Wellness, LLC all my rights, title, and interest to medical reimbursement benefits under my insurance policy with the above documented insurance companies. I hereby acknowledge and accept responsibility for payment in full of all services rendered to me by Renovation Health and Wellness, LLC.

Patient Consent for Medical Treatment

I, the undersigned, am the patient, or the patient's duly authorized representative, and do hereby voluntarily consent to and authorize medical care and treatment by Renovation Health and Wellness, LLC through its individual healthcare providers, employees, and/or agents. This care and treatment encompass all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the healthcare provider and provided by Renovation Health and Wellness. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations performed by the health care provider or employees of Renovation Health and Wellness, LLC. I acknowledge that I have received a copy of Renovation Health and Wellness's Notice of Privacy Practices and I understand that the notice is also posted at their location where services are provided and on the Internet at www.jacksborourgentcare.com. To protect against the transmission of blood-borne diseases such as Hepatitis B and Acquired Immune Deficiency Syndrome, I understand that it may be necessary to test my blood for certain diseases while I am a patient of Renovation Health and Wellness. I understand and consent that my blood, as well as the blood of any person accidentally exposed to my blood, will be tested. I further understand that my blood will not be tested for these diseases unless ordered by my healthcare provider and that the results of all tests will be kept confidential. I have read this form, or had it read to me, and I certify that I fully understand and accept its contents unless noted.

____ ____

Date Signature of Patient/Guardian/Power of Attorney

____ ____

Date Witness Signature