

Non-Covered Release Form

Site Name: URGENT TREATMENT CLINICS - _____
Location of Clinic

Patient Name: _____

Patient S.S. #: _____ **Patient D.O.B.** _____

Patient Address: _____

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

Home Phone: _____ **Cell Phone:** _____

Responsible Party: (if not same as patient): _____

Social Security # of Responsible Party: _____

Driver's License # and State: _____

I have been notified that my insurance may/does not cover services for today's visit and I understand I am financially responsible for all incurred charges.

I further understand that I must pay the charges in full at the time of service.

Signature of Responsible Party

Date