



150 S. Andrews Ave (Ext)  
Suite #201  
Pompano Beach, FL 33069

www.BrowardOutpatientUrgentCare.com  
Phone: 1.888.646.2273  
Fax: 1.888.745.7020

**PLEASE READ CAREFULLY & INITIAL IN PROVIDED SPACE:**

(If you are under 18 years of age, please have a parent or guardian read, initial and sign, in the spaces provided below)

I certify all the information contained within this questionnaire is true. There are no false, misleading or incomplete statements.

\_\_\_\_\_ I authorize BROWARD OUTPATIENT URGENT CENTER, LLC (hereafter referred to as “Your Company” to fill out and submit all necessary insurance claim forms).

\_\_\_\_\_ I authorize Your Company to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, X-Rays and physical finding, diagnosis and prognosis in accordance with Automobile No-Fault Insurance Act.

\_\_\_\_\_ I understand that Your Company requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with Your Company’s business manager. If account in not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collection your account. We have the right to collect you deductible and co-insurance.

\_\_\_\_\_ I understand that Your Company reserves the right to alter, add, or omit any of the agreements set forth on this form as deemed necessary, and without notice.

**PLEASE CHECK ONE OF THE TWO FOLLOWING STATEMENTS:**

I, DO, authorize BROWARD OUTPATIENT URGENT CENTER, LLC with the right to mail or call my resident or work with correspondence.

\_\_\_\_\_ I, DO NOT, authorized BROWARD OUTPATIENT URGENT CENTER, LLC with the right to mail and or call my resident or work with correspondence.

\_\_\_\_\_ I understand that any attempt to defraud any insurance company or other person, by intentionally concealing or providing false information for the purpose of misleading, thereto commits a fraudulent insurance act, which is a criminal offense.

In witness whereof the undersigned have hereunto read, understood, and agreed to all of the terms and conditions set forth above, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Witness to Responsible Party’s Signature

\_\_\_\_\_  
Responsible Party’s Full PRINTED Name

\_\_\_\_\_  
Responsible Party’s Signature

\_\_\_\_\_  
Responsible Party’s Social Security Number