Patient Registration

PLEASE USE LEGIBLE HANDWRITING

Reason for the visit: _____

PATIENT INFORMATION:

Last Name _____ First Name _____Middle Initial _____

Date of Birth _____ Gender: F M Other

Cell Phone_____

Email address_____

Home / Work Phone _____

Mailing Address:_____City:_____ State: _____ Zip_____

Marital Status _____Social Security # _____

RESPONSIBLE PARTY INFORMATION (if different from above or patient is a minor):

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Gender: F M Other

Cell Phone _____

Email address: _____

Home / Work Phone _____

Mailing Address:_____City:_____ State: _____ Zip_____

Relationship to the Patient: _____Social Security # _____

INSURANCE POLICY HOLDER INFORMATION

Primary Insurance: _____ Subscriber ID #:_____Group #:_____

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Gender: F M Other

Relationship to the Patient: _____ Social Security _____

Emergency Contact (name):_____

Relationship to the Patient: _____ Cell Phone _____

I certify that the information provided above is complete and accurate to the best of my knowledge.

_____

Signature of Patient or Patient Representative Date

Revised 02/22/2024

Patient Acknowledgement & Consent Form

Please initial and sign to select your current method of coverage, and to complete the acknowledgement and consent form for Medical Treatment, Notice of Privacy Practices, and Payment Policy.

____ **Self-Pay Patient Visit**

By signing below, I acknowledge that I have been informed of my responsibility to pay for the professional services provided to me today by Urgent Care Cure. I understand that these costs must be paid prior to provision of such services through its authorized representatives. I acknowledge and fully understand that the service(s) requested today will not be billed to any insurance carrier(s) at my request. I also understand that today's service(s) will be provided at a discounted rate and waive any right that I may have to require Urgent Care Cure to attempt to bill any insurance carrier(s) for these services. I further acknowledge that if I choose to submit an itemized receipt to any insurance carrier(s) for evaluation of partial or full reimbursement for these services, that Urgent Care Cure is exempt from any subsequent dispute regarding reimbursement, but retains the option to submit the claim for payment under the non-discounted insurance rates and guidelines upon mutual agreement by both parties when appropriate insurance information has been provided to Urgent Care Cure.

____ **Health Insurance Patient Visit**

I request that payment and authorized insurance benefits, including Medicare, be made on my behalf for any professional services provided to me by Urgent Care Cure. I acknowledge that I have provided my insurance information today and authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related professional services by Urgent Care Cure to the Health Care Financial Administration, my insurance company or other entity upon request to secure payment of my benefits. I understand that I am financially responsible to Urgent Care Cure for any charges not covered by health care insurance. It is my responsibility to notify Urgent Care Cure of any changes in my health care coverage with 7 days of such a change. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I understand that I am responsible for the entire bill including any unpaid balance of the professional services as determined by Urgent Care Cure and / or my health care insurer should submit a claim or any part of the claim be denied for payment or apply to my co-pay, deductible or coverage limitations.

____ **Consent To Medical Treatment**

I voluntarily present for treatment and consent to my Urgent Care Cure provider to provide care to me. Such care may include, but not limited to taking history of present medical illness, physical examination, diagnostic procedures, X-rays, blood draws, laboratory tests, medication administration, and other procedures considered advisable in my condition, treatment, and course of care.

____ **Notice of Privacy Practices**

By signing this document, I acknowledge review of Urgent Care Cure Notice of Privacy Practices, with a copy available upon request, as required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

____ **Payment Policy**

It is Urgent Care Cure policy to require all co-payments, and past due balances to be made at the time of service. All accounts over 90 days, after being processed by the provided insurance and not paid by the responsible party after reasonable attempts to collect the payments by Urgent Care Cure via phone calls, text messages, and emails, may be submitted to Collection Agency. In case uncollected balance is submitted to the Collection Agency a Fee of $40.00 will be added to the balance by Urgent Care Cure to offset the Collection Agency charges. In the event any balance is not paid as agreed, the undersigned agrees to pay all costs charged by the Collection Agency and potential attorney fee. I understand that by signing this form I am accepting full financial responsibility as explained above for all professional received. I understand this original authorization will be kept on file by Urgent Care Cure and does not expire, unless a written notice is provided by me.

Signature of Patient / Guardian _____

Name of a Patient / Guardian _____

Date: _____

Medical / Surgical / Social History

PATIENT INFORMATION:

Last Name _____ First Name _____Middle Initial _____

Date of Birth _____ Gender: F M

Medications Allergies:_____

_____

Past Medical History:_____

_____

_____

_____

Past Surgical History: _____

_____

_____

_____

Current Prescribed Medications: _____

_____

_____

_____

_____

_____

Social History:

Nicotine Use: __ Cigarettes __ Vaping __ Former Smoker_____

Alcohol Use: __ Never __ Rare __ Once a week __ Two – Three times a week __ Daily_____

Marijuana Use: __ Never __ Rare __ Once a week __ Two – Three times a week __ Daily_____

Illicit Drug Use: __ Never __ Rare __ Occasional __ Daily_____

___/___/2024