Like us on Facebook

HEALTH MED URGENT CARE
Healthcare Made Convenient

www.Facebook.com/healthmedUC**REGISTRATION FORM**

PLEASE FILL OUT FORM COMPLETELY

Today's Date:	**Time:**	**PRIMARY CARE DOCTOR:**

PATIENT INFORMATION

Patient's last name:	**First:**	**Middle:**	**Marital status:**
Race:	**Ethnicity:Preferred Language:**		

Is this your legal name? ○ Yes ○ No	**If not, what is your legal name?**	**Birth date:**	Age:	Sex: ○ M ○ F

Address:	**City:**	**State:**	**Zip:**

Social Security no.:	**Home phone no.:**	**Cell phone no.:**	**Email Address:**

How did you hear about us today (website (ex: google, yelp, yodel), newspaper, insurance, other) (if other explain)?

Please explain what brings you into the office today. If it is an injury please let us know if it is work, or car accident related.

INSURANCE INFORMATION

(Once done please give your insurance card to the receptionist.)

Insurance Carrier:

Subscriber's name:	**Subscriber's S.S. no.:**	**Birth date:**	**Group no.:**	**ID no.:**	**Co-payment:**

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	**Subscriber's name:**	**Group no.:**	**Policy no.:**

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	**Relationship to patient:**	**Home phone no.:**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature **Date**

Summary Notice of Privacy Practice

The Following is a brief summary of your rights and our responsibilities as detailed in the Notice of Privacy Practices. This summary is for your convenience and is not a substitute for reading the entire Notice and does not modify the terms.

1. Uses and Disclosures: We may use the Information we develop and collect for treatment by our practice or disclose the information to others whom we refer you to for treatment, payment, and certain health care "operations" such as improving competence and quality. We may disclose your information to transcription or billing services. We may call your home or mobile phone and may leave a message on your answering machine if you have one. We may disclose information to you or your family about your location, general condition or death. If you are available and able, we will ask your consent first. We will not disclose your information for marketing purposes without your written permission.

   Your medical information may be disclosed without your authorization as required by law, for public health purposes.

2. Other Uses and Disclosures: Except as described in the notice, we will no use or disclose your medical information without your written authorization. You can revoke an authorization at any time, except to the extent that we have already taken action in reliance on the authorization.

3. Your Health Information Rights: You have a number of rights under the state and federal law which ar subject to the terms and condition specified in the Notice.

   a) You may request restrictions on certain uses and disclosures of your information.
   b) You may request that you receive your information from us in a certain way.
   c) You may inspect and request a copy of your medical records.
   d) You may request an amendment to anyrecord you believe is inaccurate.
   e) You may request an accounting of disclosures make of your records
   f) Authorization to release medical records to:

Please indicate the name of the individual or entity to whom you authorize release of your medical records, as well as their relationship to the patient.

Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:

Acknowledgment of Receipt of Notice of Privacy Practices

Print Name:	Signature:	Date:

HEALTHMED URGENT CARE
Healthcare Made Convenient

Billing Policy

The following describes the general billing policy of HEALTHMED URGENT CARE. Please review this information and sign where indicated.

- I understand that it is my responsibility to provide the office of HEALTHMED URGENT CARE, accurate insurance and billing information, and to notify the office of any changes to this information.
- I understand that if I do not have insurance I am responsible for the full bill of today's visit at time of service unless a payment plan was agreed upon between the doctor and I, which in turn will be written up and signed by both myself and the office.
- I understand that if I present a check for payment on with insufficient funds, that I will be charged a NSF fee of $20. I further understand that to rectify my account, I will be required to pay with cash, a money order or cashier's check, or credit card.
- I understand that any co-payments/co insurance and /or deductibles are due and payable at the time of service. HEALTHMED URGENT CARE employs a service which will mail statements for any balance after insurance payments. I further understand that if I have not made payment after the second statement being mailed, that the subsequent statement will be marked as "Final Notice" and will be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I may be responsible for any collection, interest or other expenses associated with the collection efforts.
- I understand that the clinic will assist in obtaining the necessary prior authorizations prior to rendering treatment, further I understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier depending on the requirements of my policy. In the event that the prior authorization process is rendered ineffective by my carrier such as their failure to answer their phones, excessive wait time on their voicemail system, and unreasonable administrative requirements, that I will be responsible to these authorizations directly. Prior authorization determinations from health insurance companies are decisions based on financial concerns and are not intended to represent medical recommendations from the insurance company. The patient retains the responsibility to decide whether to pursue the best treatments options, or not to pursue them and suffer the health consequences, regardless of cost controlling measures and denials generated by their plans.
- I understand that the clinic may also take a verbal request to use my listed credit card for payment on my account.

My Signature below confirms that I have read these billing policies and consent to my financial obligations as outlined therein.

Full Signature _____ Date _____

Print Name _____ Relationship to Patient _____