PROFESSIONAL URGENT CARE SERVICES

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Home address:	Home phone no.: ( )	Cell phone no.: ( )

Apartment #:	City:	State:	ZIP Code:

Social Security no:	Email Address For Patient Portal Use:	Race and Ethnicity:

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ________ ❑ Insurance Plan ❑ Attorney

❑ Family ❑ Friend ❑ Close to home/work ❑ Internet ❑ Other: ________________________________

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Primary Insurance Co:

Policy Holders Name:	Policy Holders S.S. no.:	Birth date: / /	Group no.:	Policy no.:	

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Policy Holders name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY (REQUIRED)

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

PREFERRED PHARMACY

Pharmacy Name:

Location (cross streets):

PLEASE COMPLETE REVERSE SIDE

NOTICE OF PRIVACY PRACTICES

See office file, copies of this form are posted at the front desk.

I hereby acknowledge that I have received and read a copy of Professional Urgent Care Service's HIPAA: Notice of Privacy Practices.

Patient/Guardian signature ***Date***

CONSENT FOR TREATMENT, GUARANTEE OF PAYMENT, AND RELEASE OF INFORMATION

- I consent to evaluation and treatment by Professional Urgent Care Services physicians and health care providers. I understand that my treatment and care may include routine care, such as immunizations, and a variety of other medical services depending on my condition, such as laboratory testing and x-ray. This consent will be effective for 1 year after the date it is signed at Professional Urgent Care Services or until I am a patient at Professional Urgent Care Services again.
- I give permission to Professional Urgent Care Services providers and other staff members to release any information about me, my health, the health services provided to me, or payment for my health services, that may be necessary:
  - For my treatment to other health care providers or facilities that need the information for my continued care;
  - For any payment related matters to insurance companies or third parties and/or related entities.
- I agree to allow Professional Urgent Care Services its employees and affiliates to leave message on a voice mail on the numbers I have provided.
- I hereby authorize payment directly to Professional Urgent Care Services for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I hereby authorize Professional Urgent Care Services to utilize my e-mail address for the purposes of billing notification and e-statement delivery.
- Fees incurred in Collection or Litigation of any unpaid balances will become the responsibility of the patient or guarantor. I irrevocably assign my benefits to Professional Urgent Care Services including the right to sue my insurance company for denials or reductions. I also agree that if a referral is needed by my primary doctor, it is my responsibility to obtain it. I authorize the above medical provider to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

The above information is true to the best of my knowledge.

Patient/Guardian signature ***Date***