PHYSICIAN one URGENT CARE

31 Old Route 7 t: 855.349.2828
Brookfield, CT 06804 f: 203.885.0813

Patient Registration Form

PATIENT INFORMATION

(This section refers to the patient ONLY)

Last Name: _____**First Name:** _____**MI**: _____**SSN:** _____

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

DOB: _____

Sex: ☐Male ☐ Female

Contact Numbers (please check preferred #)

☐ **Home:** _____

☐ **Cell:** _____

☐ **Work:** _____

Please provide your email address so that we can let you know about any insurance carrier changes, health alerts, changes in hours, new clinic locations, changes to our services and other important issues. This information will not be provided to a Third Party.

Email:_____

It is our general policy to follow-up on your care by contacting you within 48 hours of your visit. If you do not wish to be contacted, please check the box: ☐

Primary Care Physician's (PCP) Name: _____**City/State:** _____

Preferred Pharmacy: _____ **City/State:** _____

EMERGENCY CONTACT

Last Name: _____**First Name:** _____**Phone Number:** _____

Relationship to the Patient: ☐ Parent ☐ Spouse ☐ Other _____

RESPONSIBLE PARTY

(This section refers to the person/party who should receive the bill)

Relationship to the Patient: ☐ Self (skip to next section) ☐ Parent ☐ Spouse ☐ Other (skip to next section) _____

Last Name: _____**First Name:** _____**MI**: _____**SSN:** _____

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

Home phone: (_____)_____**Cell phone:** (_____)_____**Work phone:** (_____)_____

INSURANCE INFORMATION

(This section refers to the Insurance Subscriber)

Last Name: _____**First Name:** _____**DOB**: _____**SSN:** _____

Relationship to Patient: ☐ Self (skip to next section) ☐ Parent ☐ Spouse ☐ Other (skip to next section) _____

Insurance Carrier: _____

Do you have insurance with more than one health plan? ☐ Yes ☐ No

If yes, please list other insurance carrier: _____

➡ *Please present both ID cards at check-in.*

MEANINGFUL USE

In consideration of the new federal Meaningful Use guidelines, as a patient at PhysicianOne Urgent Care, we ask that you provide information about your race, ethnicity, and primary language. How does this benefit you? It allows us to provide patient-specific education resources. Data on disparities of care, especially in areas with a very diverse population and/or specific population health indicators, are critical to address those disparities and improve the health care system for all. You have the right to decline to provide this information.

Preferred Language:	**Race:**	**Ethnicity:**
☐ English ☐ Spanish ☐ Portuguese ☐ Other _____	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other _____	☐ Hispanic or Latino ☐ Not Hispanic or Latino

ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT GUARANTEE

In consideration of services provided by PhysicianOne Urgent Care I hereby assign and transfer to PhysicianOne Urgent Care any and all rights which I have against insurance companies, governmental agencies, or third party payers, for payment of charges for services provided by PhysicianOne Urgent Care to me or to one of my dependents. I understand that I am responsible for and will pay the portion of my bill not covered by insurance companies, governmental agencies or third party payers. In consideration of services to be provided, I agree to pay PhysicianOne Urgent Care in accordance with the regular rates and terms of PhysicianOne Urgent Care. I further agree to pay the account in full upon receipt of my billing statement unless payment arrangements are made in advance. I authorize said payments to be applied to any unpaid PhysicianOne Urgent Care balance for which I am responsible. I agree to pay all costs of collections, including reasonable attorneys' fees, on all past-due amounts. I understand that any checks returned by my financial institution will incur a $20.00 returned check fee. I understand that as a contractual obligation with insurance companies, all copays and high deductibles are due at the time of service and that a balance still may be due after the insurance payment has been applied.

_____
Initials

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been given a copy of the PhysicianOne Urgent Care Notice of Privacy Practices, and have had the opportunity to thoroughly read and have had any questions answered about the Notice of Privacy Practices.

Please indicate the name of any individual or entity to whom you authorize PhysicianOne Urgent Care to release medical information and/or records, as well as their relationship to the patient:

_____

Relationship to the Patient: ☐ Parent ☐ Spouse ☐ PCP ☐ Other _____

☐ I DO NOT give my permission for PhysicianOne Urgent Care to leave a message with my health information. _____
Initials

For Office Use Only
A good faith effort was made in attempting to obtain written acknowledgement of receipt of the Notice of Privacy Practices. Acknowledgement could not be retained for the following reasons:

☐ Patient/Representative Refused to Sign - Date of Refusal _____

☐ Communication Barriers prohibiting obtaining an acknowledgement

☐ An emergency situation prevented us from obtaining an acknowledgement

☐ Other; Please Explain _____

Staff Signature _____Staff Initials: _____

ADVANCE DIRECTIVES

Please take special note: PhysicianOne Urgent Care does not honor advance directives, such as Do Not Resuscitate Orders or Living Wills. The Providers at PhysicianOne Urgent Care will attempt to resuscitate, stabilize and arrange for the transfer of the patient to the hospital, should an emergency arise. By initialing below, I am acknowledging the foregoing, waiving and suspending any existing advance directive which I may have while being treated at PhysicianOne Urgent Care, and releasing PhysicianOne Urgent Care and its Providers from any liability for refusing to honor any such advance directive.

_____
Initials

SIGNATURE

I certify that the information provided is correct to the best of my knowledge. I will not hold PhysicianOne Urgent Care, its health providers, or its employees responsible for any errors or omissions that I may have made in completing the information on this form. I hereby voluntarily consent to treatment for me or my dependent at PhysicianOne Urgent Care and authorize such treatments, examinations, medications and diagnostic procedure (including, but not limited to the use of lab and radiographic studies) as ordered by its providers. I hereby voluntarily consent to the taking of photographic images for treatment purposes only (wound care progression, documentation of rashes, etc.) as ordered by such providers.

Print Name: _____ **Relationship to Patient:** _____

Signature: _____ **Date:** _____