PHYSICIANOne URGENT CARE

Patient Registration Form

Patient Information

Sex: ☐ Male ☐ Female

Name: _____ Birth Date: _____
First Middle Last

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

Email: _____ Cell: _____ Home: _____

Primary Care Physician: _____ _____
Name Address

Preferred language: ☐ English ☐ Spanish ☐ Other: _____ Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Race: ☐ American Indian ☐ Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander

☐White ☐ Other _____

Preferred Pharmacy: _____ City: _____ State: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Employer Name: _____ Address: _____

Insurance Information

Guarantor (Complete if patient is under 18)

Primary Insurance: _____ Policy Number: _____ Group Number: _____
Name of Person Responsible for the Bill: _____ Birth Date: _____
Subscriber's Name: _____ Subscriber's Date of Birth: _____
Address: _____ Best contact number: _____
Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary Insurance: _____ Policy Number: _____ Group Number: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Notice of Privacy Practices

I acknowledge that I have been given/offered 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.

Initials ____

I authorize PhysicianOne Urgent Care to release medical information and/or records to: _____

Name of Individual/Entity

Relationship of individual/entity to patient: ☐ Parent ☐ Spouse ☐ PCP ☐ Other _____

☐ I ***do not*** give my permission for PhysicianOne Urgent Care to leave a message with my health information.

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 obtained for the following reason:

☐ Patient/Representative Refused to Sign - Date of Refusal

☐ ~~Communication Barriers prohibiting~~ obtaining an acknowledgement

☐ An emergency prevented us from obtaining an acknowledgement

☐ Other; Please Explain _____

Contacting You

By providing your contact information above, you are agreeing to receive certain information from PhysicianOne Urgent Care. For example, we may call, email or text (SMS) you with appointment reminders, follow-ups to your visit, or send you non-sensitive information such as patient satisfaction surveys, insurance carrier changes, health alerts, changes in hours, new locations, changes to our services and other important issues.

Additionally, PhysicianOne Urgent Care would like to give you the opportunity to agree to receive information of a more sensitive nature, such as test results, lab results, billing information and similar information, via text message and/or email. If you would like to receive text messages and/or email communications with such information at the number and email address you provided above, please initial below. By initialing below, you acknowledge that you have been given/offered a copy of the PhysicianOne Urgent Care Patient Email and Text Message Notice and Informed Consent, and have had the opportunity to thoroughly read, and have had any questions answered about, such document.

Initials ____

Advanced Directives

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 ____

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 ____

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:** _____