

Welcome!

Symptoms/Reason for Today's Visit? _____

PATIENT INFORMATION

 Last _____ First _____ MI _____ Gender: Male Female

Date of Birth ____/____/____ Age _____ SSN: _____-_____-_____

 Parent/Guardian Name: _____ Relationship _____
 (If patient is under the age of 18)

Mailing Address: _____ Apt # _____ City _____ State _____ Zip _____

Primary Phone (____) _____ - _____ Secondary Phone (____) _____ - _____ Country _____

Primary Care Physician _____ Phone (____) _____ - _____

Emergency Contact _____ Phone (____) _____ - _____

Employer Name: _____ Work Phone: (____) _____ - _____

HOW DID YOU HEAR ABOUT US?
 Walk/Drive by Magazine Phonebook Radio Website Facebook Twitter

 Referred By Physician Family Friend Referral name _____ other _____

Email Address _____ @ _____ *For MD Urgent Care Updates

 Yes, if possible communicate with me via email

INSURANCE INFORMATION

 **Check if applicable: Workman's Compensation Claim Auto/Car Accident Claim
 **All Workman's' Comp/Accident Claimants must complete a "Claim's Request Form"

Please see receptionist for form, Thank You!

PRIMARY INSURANCE

Plan Name _____

Policy/Subscriber ID # _____

Effective Date _____

INSURED'S INFORMATION
 Check here if patient is primary member on plan.
 (Only complete below if Primary on insurance is other than patient)

Full Name _____

Social Security # _____-_____-_____

Date of Birth ____/____/____

Relationship _____

SECONDARY INSURANCE

Plan Name _____

Policy/Subscriber ID # _____

Effective Date _____

INSURED'S INFORMATION
 Check here if patient is primary member on plan.
 (Only complete below if Primary on insurance is other than patient)

Full Name _____

Social Security # _____-_____-_____

Date of Birth ____/____/____

Relationship _____

CONSENT FOR MEDICAL TREATMENT

I hereby consent to the procedures which may be performed during this examination, including services which may include but are not limited to laboratory procedures, x-ray examination, diagnostic procedures, medical, and/or surgical treatments or procedures, anesthesia or other urgent services rendered to me under the general and special instruction of an MD Urgent Care Physician.

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received the notice of privacy practices, which describes the ways in which MD Urgent Care may use and disclose my healthcare information for treatment, payment of services, healthcare operations and other described and permitted uses and disclosures.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize the payment directly to MD Urgent Care P.C. for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for any and all charges not paid by insurance, and for all services rendered on my behalf or my dependants. I authorize the doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

FINANCIAL AGREEMENT

In consideration of the services rendered to the patient, the undersigned (as parent, guardian, spouse, guarantor, and agent or as the patient) individually promises to pay the patient's account at the rates established by the clinic for services provided. A receipt of charges for services to the patient is available upon request. All final charges are based on multiple factors, including but not limited to the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services.

I hereby consent, acknowledge and fully understand the above. I also understand there are no guarantees or assurances from anyone as to the results that may be obtained from any medical treatment or services rendered at MD Urgent Care P.C.

X _____ **DATE:** _____

PATIENT/GUARDIAN SIGNATURE
OFFICE USE ONLY

001 PASCUZZI, THOMAS	004 KIRKPATRICK, KEVIN
002 TALIAFERRO, EDWARD	005 PILETTE, GREGORY
003 WHITING, MICHAEL	006 SCHULTZ, KURT
	MEDIC NON PROVIDER VISIT
INSURANCE VERIFICATION	PAYMENT
<input type="checkbox"/> AETNA <input type="checkbox"/> GEHA <input type="checkbox"/> PRESBYTERIAN <input type="checkbox"/> *AMERIGROUP <input type="checkbox"/> HUMANA <input type="checkbox"/> TRIWEST Prior Auth _____ <input type="checkbox"/> MEDICARE <input type="checkbox"/> TRICARE <input type="checkbox"/> BCBS <input type="checkbox"/> LOVELACE <input type="checkbox"/> UNITED <input type="checkbox"/> CIGNA <input type="checkbox"/> NM MEDICAID OTHER _____	*** PREVIOUS / CREDIT BALANCE \$ _____ TODAY'S CHARGES \$ _____ ADDITIONAL CHARGES \$ _____ TOTAL PAID \$ _____ CASH / CHECK CASH / CHECK DISCOVER / AMEX / VC/MC DISCOVER / AMEX / VC/MC RECEIPT # 1 RECEIPT # 2
Insurance verified _____ By _____ VERBAL PARENTAL CONSENT Received by _____ Consenter Name _____ Relationship _____	*Non-Contracted Provider requires Prior Authorization (Note in Medware) *** Account Review for Past Due Balances or Credits
<i>For use when acknowledgement cannot be obtained from the patient</i> Documentation of Good Faith Efforts to provide MD Urgent Care's privacy notice. The patient presented to the clinic on (Date) _____ and was provided a copy of MD Urgent Care's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because: _____ Patient refused to sign _____ Patient had a medical emergency _____ Other reason (describe) _____ EMPLOYEE (PRINT NAME) _____ SIGNATURE _____	

PATIENT LABEL