PATIENT REGISTRATION INFORMATION

Patient Name: Last_____ **First**_____ **MI** _____

Date of Birth:_____/_____/_____ **Social Security #:**_____-____-_____ **Email:**_____@_____

Mailing Address: _____

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

Home Phone: (_____)_____-_____ **Cell Phone:** (_____)_____-_____ **Other:** (_____)_____-_____

Gender: [ ] Male [ ] Female [ ] Other **Please Specify:**_____

Race: [ ] Black [ ] Hispanic [ ] White [ ] Other: _____

Ethnicity: [ ] Hispanic or Latino [ ] Non-Hispanic or Latino

Please notify the staff of a disability that may require special needs or of a barrier to communication or educational instruction that would prevent the understanding of information about the patient's health status, treatment, or the informed decision making process, such as; foreign language, hearing or speech impairment, difficulty with reading or writing or inability to comprehend verbal instruction. Assistive services within our capability will be provided to you free of charge.

Emergency Contact:_____ **Phone:** (_____)_____-_____

Relationship: _____

Guarantor / Responsible Party for minor

[ ] Check box if address and phone number is the same as the patient's information.

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

Relationship to patient: _____

Date of Birth:_____/_____/_____ **Guarantor Social Security #:**_____-__-_____ **Mailing Address:** _____

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

Home Phone: ( )_____-_____ **Cell Phone:** ( )_____-_____ **Other:** ( ) _____ - _____

Guarantor Employer:_____ **Phone:** ( )_____-_____

Primary Insurance Coverage

Insurance Company:_____ **Name of Policy Holder:** _____

Relationship to Patient:_____ **Insured D.O.B.:**_____/_____/_____

Insured Social Security #:_____-_____-_____

Secondary Insurance Coverage

Insurance Company:_____ **Name of Policy Holder:** _____

Relationship to Patient:_____ **Insured D.O.B.:**_____/_____/_____

Insured Social Security #:_____-_____-_____

I verify that the above information provided is true and correct to the best of my knowledge. I understand that the company will require me to update this information at least annually and as necessary when changes occur in my status.

X_____ Date:_____/_____/_____

Signature of Patient /Guardian/Accompanying Adult

TRICARE Referral # _____

CONSENT & CHIEF COMPLAINT

Patient Name:_____ Date of Birth:_____/_____/_____

(Minors) Name of Parent/Guardian:_____ Cell Phone Number:(___) _____-_____

Chief Complaint: (Primary reason for your visit today) _____

Is this visit related to an Accident? [] No [] Yes Date Occurred: ___/___/____ Type: [] Work Related [] Auto [] Other

Primary Care Physician First & Last Name:_____ Phone: (_____) ____-_____

Pharmacy Preferred Today:_____ Location: _____

How did you hear about us?	[ ] Friend/Relative	[ ] Online	[ ] Billboard	[ ] T.V.
[ ] Magazine/Newspaper	[ ] Location	[ ] Physician Referral	[ ] Other:	

Consent for Treatment | Use of Protected Health Information | Financial Obligation

- I hereby consent to medical evaluations, testing, and/or treatment provided by the staff of this medical facility I understand that prior to treatments, procedures or receiving medications and vaccines, I will be informed of the benefits, risk and possible side effects and allowed to ask questions for full knowledge to give informed consent, and I understand that implied consent may apply in instances of serious illness, injury or altered mental status. I understand that female patients may require a pregnancy test prior to receiving certain testing, treatment, and/or written prescriptions. I understand that it is my responsibility to provide any information relevant to health history, possible medication interactions and allergies. I authorize the facility to obtain and utilize my medication history from other health care providers or third-party pharmacy benefit payers to e-prescribe my prescriptions.
- I acknowledge that I have reviewed the company Payment Policy and have been given the opportunity to ask questions and to have concerns and written request addressed. I hereby authorize the facility to accept assignment of contracted insurance benefits and I understand that I am responsible for co-insurance, co- payments, and/or deductibles at the time of service. I understand that if my insurance is a non-contracted plan (out-of-network), the facility will courtesy file the claim for services rendered and any money received by the facility will be reimbursed to me. In the event that I have no insurance coverage, I understand that fees are due at the time of service. I understand that previous balances owed to the facility will be requested at time of registration and any outstanding balance will be billed with accrued interest. I understand that the facility may be contracted with specific Medicaid plans.
- If my plan is not under contract with the facility, I may elect to accept sole responsibility for the payment of services, and the facility nor I may seek reimbursement from Medicaid for charges incurred. I understand that all fees are due at the time of service and prior to receiving discharge paperwork and/or prescriptions that complete the visit encounter.
- I understand that if the provider has ordered additional laboratory test that the collected specimens will be sent to a local laboratory for testing. The facility will forward my payer information to the laboratory, but I will be responsible for the charges incurred for these services and will receive a separate bill from the laboratory. I understand that there may be a portion of the cost of Durable Medical Equipment that is not covered by my insurance company, and I will be responsible for the balance.
- I understand that the provider may use telemedicine and video technologies, and photographs of my injury or wound, etc. for treatment, consultation, or specialist referrals. I understand that I may be referred to a health care provider for follow up care and that I will be given the freedom of choice in referral selection. If I do not have an established health care provider and have no preference in selection, I understand that my PHI may be sent to an affiliated health care organization to follow up with me to help coordinate my care. I understand that my insurance may not cover the services for which I am being referred and that I should verify coverage with that provider prior to my visit.
- I understand that the company may use or disclose my Protected Health Information (PHI) necessary to carry out treatment, payment, or healthcare operations or in other instances as permitted by HIPAA. I opt to authorize the company to use and disclose my PHI utilizing health information exchange portals for continuity of care. I understand that the contact information I provide such as my physical address, phone number and email may be used to provide me with information on health-related benefits and services that may be of interest to me, to provide me with marketing and fundraising material and to send me patient satisfaction surveys. I acknowledge and agree to my survey feedback being used on an anonymous basis on the website or other public sites to identify comments that the public may view and objectively review. I understand that I have the right to opt out or unsubscribe to any information, materials, or survey that I may receive.
- I acknowledge that I was provided access to the Notice of Privacy Practices, the Notice of Nondiscrimination and the Patient Rights and Responsibilities. I have been allowed the opportunity to ask questions, to file a complaint to have my concerns addressed, to submit a special written request and to object to the release of my PHI to a specific person if I so choose.
- You expressly consent and agree that, in order to discuss or service your account(s) (the "Accounts") or to collect amounts you may owe, (Statesboro Urgent Care), and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively, "We") may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contact you by sending text messages, emails, using any e-mail address you provide to us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

X_____ _____ Date:_____/_____/_____

Signature of Person Giving Consent
Patient/Guardian/Accompanying Adult

Relationship