PATRIOT URGENT CARE

PATIENT INFORMATION

Name _____ Primary Physician _____

Address _____ Address _____

City, State, Zip _____ Phone _____

Mobile PH._____ 2nd Phone _____ Pharmacy _____ Phone _____

SS# _____ DOB _____/____ /_____

Email _____

Sex: ❑ M ❑ F **Marital Status**: ❑ Sing. ❑ Mar. ❑ Div. ❑ Sep. ❑ Wid.

Employer: _____ Phone:_____

How did you hear about us? ❑ Word of mouth ❑ Drove By ❑ Web

❑ Insurance ❑ Billboard ❑ Other_____

We are required to ask the following based on governmental regulations:

❑ African American ❑ American Indian or Alaska Native

❑ Asian ❑ Caucasian\ White

❑ Native Hawaiian ❑ Non-Latino or Non-Hispanic

❑ Latino or Hispanic ❑ Prefer not to answer

Preferred Language: ❑ English ❑ Spanish ❑ Other:_____

❑ **Yes** / ❑ **No** If I am unavailable, I authorize **Patriot Urgent Care** to contact me by phone or text to discuss Personal Health Information at the phone numbers provided.

EMERGENCY CONTACT

Name _____ Mobile Phone _____

Address _____ 2nd Phone _____

City, State, Zip _____ Relationship _____

I ❑ **do** / ❑ **do not** authorize the disclosure of Personal Health Information to certain designated individuals other than myself as listed below:

❑ **Same as above** Name _____ Relationship _____ Phone _____

INSURANCE

❑ check if same information as patient

Primary Carrier ❑ BCBS ❑BCBS FEB ❑Aetna ❑Cigna ❑Humana ❑ Medicare ❑TriCare Std ❑ TriCare Prime ❑TriCare Life ❑ Other: _____

Secondary Carrier ❑ BCBS ❑BCBS FEB ❑Aetna ❑Cigna ❑Humana ❑ Medicare ❑TriCare Std ❑ TriCare Prime ❑TriCare Life ❑ Other: _____

Name _____ Name _____

Member ID_____ Member ID_____

Group #_____ Group #_____

Policy Holder _____ Policy Holder _____

DOB _____/_____/_____ Relationship _____ DOB_____/_____/_____ Relationship _____

Address _____ Address _____

ACKNOWLEDGEMENTS

I have been advised of and provided access to **Patriot Urgent Care** *Notice of Privacy Practices* and I agree to the authorization to treat and financial policies on the back of this page. _____ Initial Here

I hereby ❑ **do** / ❑ **do not** authorize **Patriot Urgent Care** to release any of my Personal Health Information via general mail, including materials of a potentially sensitive nature, such as laboratory or radiology reports, HIV or STD testing results, or mental health treatment records to the address provided.

The above information is true to the best of my knowledge: I hereby authorize my insurance benefits to be paid directly to the practice. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize **Patriot Urgent Care** to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance submissions.

Signature _____ Date _____

Printed Name _____

These authorizations, acknowledgements, and waivers cover all services rendered for today's services and for all future dates of service.

AUTHORIZATION TO TREAT

You agree to give authorization to receive treatment by our medical staff and release **Patriot Urgent Care (PUC),** its Owners, Physicians, Physician Assistants, and Nurse Practitioners, and/or any clinical staff member from any liability claims that may result from any treatment, medications, and/or procedures that have been provided to you.

You may be seen by a Nurse Practitioner or Physician Assistant, who are highly qualified to meet the medical needs of our patients. If you do not wish to be treated by a Nurse Practitioner or Physician Assistant, please inform the front desk personnel.

FINANCIAL POLICY -Payment for rendered services

All account balances, co-pays, co-insurance, and self-pay charges are due prior to services being rendered. If a self-pay patient, final incremental patient charges will be determined based on the self-pay schedule after the visit is rendered. For patients with insurance, any additional patient charges will be determined after filing with the relevant insurance carriers and charged separately at that time.

Accounts with a balance must be paid prior to being seen. For delinquent/bad debt accounts, we reserve the right to turn the account over to a collection agency. Once your account is transferred to a collection agency, all further correspondence must be with them. Having your account in collections could interfere with us providing you medical care in our office.

As a courtesy, we will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

In the event that your insurance fails to pay for services rendered at **PUC** (e.g., deductible not met, out-of-network charges, denial of claim, cancelation of coverage, etc.), in signing this, you agree to be responsible for any remaining balance, with the exception of an adjusted contractual agreement, within sixty (60) days of service. Beyond 60 days, balances may incur a late payment penalty fee up to the maximum allowed by law and/or may be turned over to a third-party collection agency.

You also agree that to service your account or collect monies that you may owe, we may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you may provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

Patients who are self-pay and those with insurance should be aware that we cannot give an exact price for your services prior to you seeing the provider. Charges will depend upon the services rendered for your care and your particular insurance plan.

In reading this, you understand that **PUC** may send lab specimens to an outside laboratory or send x-rays taken at **PUC** to an outside radiologist for over-read. Charges incurred for laboratory tests or other services may be billed to you separately by that vendor.

Payment can be made by: Cash, Check, or most Major Credit/Debit Cards.

All returned checks, stop payments, and credit card disputes/reversals will incur a fee of $30.00.

All products sold in our office are non-returnable.

For our patients **without insurance**, payment for a Basic Office Visit is expected prior to being seen. If there are costs associated with any additional services provided to you, payment for these services must be paid in full prior to departure from the center.

For our patients **with insurance**, all co-payments are required at time of service.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

In signing this document, you acknowledge your understanding that Privacy Practices are posted for your information. To note, you have the right to opt out of the health information exchange that **PUC** participates in as a member of the Emory Healthcare Network. A copy of the Privacy Practices can be provided to you upon request.

TEXT MESSAGING

By providing a mobile number, you consent to receive text messages regarding your experience and medical care from our automated system. You can choose to opt out of receiving text messages regarding your experience; but you may continue to receive messages regarding your medical care. To opt out of all messaging, you can choose not to give us your mobile number. Giving us your mobile number is not a condition of service; however, we do ask that you give us a way to contact you quickly so that we are better able to communicate with you regarding your medical care.