Patient Registration

Your insurance card and photo ID are required at the time of your visit.

Last Name: _____ First Name: _____ MI: _____

DOB: _____ (mm/dd/yyyy) Age:_____ Sex: _____ SS#: _____

Address: _____ Apt:_____City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work _____

Email: _____

Race (circle all that apply): American Indian, Asian, Black, Hawaiian, Hispanic, White, Other (please specify) _____
Ethnicity: Hispanic or Latino? Y or N

Responsible Party (required if the patient is under 18 and/or if the guarantor is not the patient)

Name: _____ Relation: _____ Address: _____

City: _____ State: _____ Zip:_____ Phone: _____

Social Security Number: _____DOB: _____

Emergency Contact Information

Contact First Name: _____ Contact Last Name:_____

Contact Phone: _____

Relationship to Patient: _____Address: _____

City: _____State: _____ Zip: _____

How did you find us? __Internet (Please Specify Website:_____) __Live nearby __Friends/Family __Other (Please Specify):_____

Other Family Seen Here

Name: _____ Relationship to Patient: _____

Primary Care/Other Physician

Physician Name: _____ Practice Name: _____

Address: _____City: _____ State: _____ Zip: _____

Employment Status *(Circle one)*

Employed Unemployed Full Time Student Part Time Student Retired Child

Business Name: _____ Business Phone: _____

Is this an on the job accident? Yes No

Date of Injury _____

Is this a motor vehicle accident? Yes No

I **agree and consent to releasing information to me in the following manners:** *(Please initial)*

Via Mail Ok to mail to home address _____ **Via Email** Ok to leave detailed message _____

Via Home Telephone Ok to leave detailed message_____ **Via Texts** Ok to text for appointment reminders if applicable _____

Via Work Telephone Ok to leave detailed message_____ Any restrictions on the type of information?_____

Assignment of Insurance Benefits: I authorize payment directly to QUICK URGENT CARE LLC for all benefits otherwise payable to me.

Guarantee of Payment: I understand that I am financially responsible **and** agree to pay all of the charges that are not paid by or billed to my insurance company or any other third party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance co-pays, co-insurances, and deductibles today. If you are unable to verify my insurance at the time of service, I will pay for all services. I am responsible for knowing and understanding the benefits and limitations of my insurance coverage.

By signing below, I attest that the information provided above is true and accurate,

Signature of Insured/Guardian: _____Date: _____

Reason for Being Seen Today: _____

Pharmacy Name/Address: _____

Pharmacy Phone Number: _____

Insurance Information

Primary Insurance

Insurance Company: _____ Group#: _____ ID#: _____

Policy Holder Name: _____ Relationship to Patient: _____

Social Security #:_____ DOB:_____

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

Phone #: _____ Ext: _____ ❑ Same as mine ❑Same as Responsible Party

Insured Employed by: _____ Business Address: _____

City: _____ State: _____ Zip: _____ Business Phone #: _____

Secondary Insurance

Insurance Company: _____ Group#: _____ ID#: _____

Policy Holder Name: _____ Relationship to Patient: _____

Social Security #:_____ DOB:_____

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

Phone #: _____ Ext: _____ ❑ Same as mine ❑Same as Responsible Party

Insured Employed by: _____ Business Address: _____

City: _____ State: _____ Zip: _____ Business Phone #: _____

Authorization to release or use information for treatment, payment, or health care operations

I hereby authorize the release or use of my individually identifiable health information (Protected Health Information or PHI) and medical information by Quick Urgent Care in order to carry out treatment, payment or health care operations. You should review our Notice of Privacy Practices for a more complete description of the potential release and use of such information. You have the right to review such Notice prior to signing this Consent Form — it is available from our front desk staff.

Quick Urgent Care reserves the right to change the terms of the Notice of Privacy Practices at any time. If we do make changes to the terms of the Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

I have the right to request that Quick Urgent Care further restrict how my PHI is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, or later revoke it, Quick Urgent Care may decline to provide treatment to me.**

Authorization to release information to a family member/friend

As required by the Health Insurance Portability and Accountability Act of 1996 you have a right to nominate one or more persons to act on your behalf with respect to your PHI. By completing this form, you are informing us of your wish to designate the named person as your personal representative with respect to uses and disclosures of your PHI.

I, _____ (printed name and date of birth), hereby nominate the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of my PHI:

_____ *(Printed Name of Personal Representative)*

The authority of this person, when acting as my personal representative, is restricted to the following functions:

This person is to be afforded all of the privileges that would be afforded to me with respect to my Protected Health Information.

I acknowledge and understand that I may revoke this designation at any time by writing. I further acknowledge and understand that any revocation does not apply to the extent that persons authorized to use or disclose my Protected Health Information have already acted in reliance on this designation.

By signing below, I consent to be treated at QUC. I attest that the information given is accurate to the best of my knowledge. I have been given access to a copy of the Notice of Privacy Practices, Financial Responsibilities and Ownership Disclosure. I understand and agree to the terms above. Changes to any provision of this agreement will not affect the validity of any other provision in this agreement.

Signature of Patient/Guardian: _____ Date: _____