PREMIER URGENT CARE

Patient Registration Form

Information identified with * is required

Thank you for choosing Premier Urgent Care. Please complete all applicable fields below. This information will remain confidential.

Patient Information

***Patient Full Name:**			Date: / /
***Date of Birth:** / /	SSN: - -	Gender: ☐M ☐F	Marital Status: ☐S ☐M ☐D ☐W
***Address:**		Primary Care Physician (PCP):	
***City:** ***State:** ***Zip:**		Did PCP refer you to Premier? ☐Yes ☐No	
***Main Phone:** Cell Phone:		PCP Address:	
Email: (used for health alerts, insurance carrier changes, Premier Urgent Care services and new locations)		PCP Phone:	
Preferred Pharmacy:		City: State: Zip:	
Emergency Contact:		Emergency Contact Phone:	
How did you hear about Premier? : ☐Healthcare Referral ☐Friend/Family ☐Print Ad ☐Mailer ☐ Event ☐ Radio ☐Online (google, etc.)			

Insurance Information

***Subscriber Full Name:**		***Name of Insurance:**
***Subscriber DOB:** / /	SSN: - -	Relation to Patient: ☐ Self ☐Child ☐Spouse ☐Other
Policy #:		Group #:
Secondary Insurance Name:		Subscriber Name: DOB: / /
Is today's visit due to an Auto Accident? ☐Yes ☐No	If yes, in which state did the accident occur?	Claim #:

Responsible Party *(if patient is not financially responsible for account)*

Responsible party full name:	DOB: / /	SSN: - -
Address:	Relation to Patient: ☐ Self ☐Child ☐Spouse ☐Other	
City: State: Zip:	Phone:	

Worker's Compensation (WC) Information and Authorization

*Employer Name:	Supervisor/HR Coordinator:	*Phone:
*Address:	*City: *State: * Zip:	
WC Carrier:	Phone:	Claim #:
Address:	City: State: Zip:	
*Date of Injury: / /	Did you report this injury to your employer? ☐Yes ☐No	

I understand and agree that I will be financially responsible for all WC charges in the event that my WC Benefits are denied.

Signature of Patient or Guarantor: **Date:**

Payment is required at the time that services are rendered unless you are a member of a participating insurance plan of Premier Urgent Care. I authorize the release of information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. If Premier bills my health insurance company on my behalf, I authorize payment to be paid directly to Premier. Any applicable co-payment, co-insurance and/or deductible will be collected at time of service. I understand that Premier Urgent Care will make every effort to identify whether my insurance is participating with Premier and has contracted to perform services at a predetermined rate; however, I am ultimately responsible for understanding my insurance coverage and whether my insurance coverage is participating with Premier and contracted to perform services at a predetermined rate. I understand that my insurance company will make the final determination as to what services are covered. I understand the terms of payment and I have been given the opportunity to read Premier's Financial Policy. I understand and accept that I am ultimately responsible for payment of services rendered by Premier if such services are not paid for by my insurance(s). I understand that a late charge of 1.5% per month may be applied to any unpaid patient balance that is not paid within 30 days from receipt of a bill. I understand that a charge of $50 is applied for any returned personal checks due to insufficient funds. I authorize my information to be accessed by all Premier Urgent Care clinics to provide continuity of care. This information includes, but is not limited to: diagnoses, prescriptions, treatment plans, lab results, referrals, and x-ray reports.

X: ____ Date: ________________________________

Signature of Patient or Guarantor

PREMIER URGENT CARE

Acknowledgement of Notice of Privacy Policy

I understand that this acknowledgement is not required to receive treatment at Premier Urgent Care. I acknowledge, under federal guidelines of the HIPAA Privacy Notice, that I have been given the opportunity to thoroughly read and have had any questions answered about the Notice of Privacy Practices at Premier Urgent Care. I acknowledge receipt of the Notice of Privacy Rights with detailed information regarding how Premier Urgent Care may use and disclose my protected health information. I understand that Premier Urgent Care reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

☐ I give permission for Premier to leave a detailed message with my health information. **My Preferred Number**:_________________

☐ I DO NOT give my permission for Premier to leave a detailed message with my health information.

X: ____ Date:______________________________

Signature of Patient or Guarantor

FOR OFFICE USE ONLY:

An effort has been made to obtain written acknowledgement of receipt of Premier Urgent Care's Notice of Privacy Practices. Acknowledgement could not be obtained for the following reason(s):

☐ Patient/Guardian refused to sign on this date: ____

☐ Communication/language barriers prohibited obtaining acknowledgement

☐ An emergency prohibited obtaining acknowledgement

☐ Other (explain) ____

Refusal to obtain acknowledgement does not prevent the patient from continuing to be treated at Premier Urgent Care.

Employee Signature**:** _________________________________ Date:______________________________

Acknowledgement of Patient Choice for Ancillary Services

Premier Urgent Care may recommend certain ancillary services as part of your overall healthcare. These services include advanced imaging, limited lab services and certain pharmaceuticals. Premier has contracted with a third party vendor of limited durable equipment so that this equipment is available to you at the time of treatment. As your healthcare provider, Premier Urgent Care will make these services available to you; however, it is ultimately your choice to accept or deny such services. You are not required to obtain these services through Premier Urgent Care. Should you accept such services, you may incur additional expenses due to services being managed by a third party vendor.

By signing this document, I, being the patient/legal guardian acknowledge my understanding of the above regarding Premier Urgent Care's Patient Choice policy and have had any questions addressed.

X: ____ Date:______________________________

Signature of Patient/Guardian

Authorization to Treat

I understand that this authorization is voluntary and I may refuse to provide authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I may inspect or copy the information to be used or disclosed, and that information used or disclosed to my primary care physician may be subject to re-disclosure by the primary care physician, and may no longer be protected by federal and state privacy regulations. I further understand that I may revoke this authorization at any time by providing written notification to the Health Information Management Department at Premier. The revocation will not affect any actions taken before the receipt of the written revocation.

By signing this document, I, being the patient/legal guardian authorize Premier Urgent Care to provide medical care in accordance with currently accepted medical standards and guidelines.

X: ____ Date:______________________________

Signature of Patient/Guardian

Consent to Treat a Minor *(if applicable)*

I confirm that I am the parent or legal guardian of the above-referenced minor. I hereby authorize Premier Urgent Care to provide medical care as it so deems necessary to the minor. In the event that the minor has received treatment at Premier Urgent Care prior to the date of this form, I hereby authorize treatment in addition to the treatment(s) of a prior date.

X: ____________________________ Date:_________________________

Signature of Patient/Guardian