

ESTABLISHED PATIENT REGISTRATION FORM

Today's Date: _____

Date of Birth: _____

Print Name: _____

Any changes to address or insurance information since last visit? **YES** **NO**

Please provide insurance card to update in system.

Reason for Today's Visit:

Was this a result of a Car Accident? Yes No Was this a result of a Job Injury? Yes No Accident/ Injury Date: _____

Pharmacy for Today's Visit: _____

HIPAA CONSENT:

Preferred Phone Number for follow up: _____ Leave a Message YES NO

You may discuss my personal health information with: _____

(Name)

(Relationship)

(Phone Number)

Authorization and Release:

Authorization for Treatment: I voluntarily consent to the administration and cost of medical and surgical procedures for myself or my dependent.

Assignment of Benefits: I authorize payment directly to HMH URGENT CARE MANAGEMENT PC for all benefits otherwise payable to me.

Guarantee of Payment: I understand that I am financially responsible and agree to pay all charge that are not paid or billed to insurance 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, coinsurances and deductibles today. If you are unable to verify my insurance at the time of service, I will pay in full for all services.

Release of Records: I authorize HMH URGENT CARE MANAGEMENT PC to release (verbal and in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment or other health care operation which may be liable to me or my practitioner(s) for charges for this treatment and for quality management, utilization review, transfer, continuation of care and follow-up purposes.

Receipt of Privacy Practices: I acknowledge that I have received and/or read the Notice of Privacy Practices of HMH URGENT CARE MANAGEMENT PC. I understand that a copy of this agreement may be used with the same effectiveness as the original.

Patient Signature (Parent or Guardian if under 18)

Date