Beechmont Urgent Care

Registration Form

Welcome to Our Office: Please complete the following information for your file. (Please print)

WHAT IS THE REASON FOR YOUR VISIT TODAY? ______________________________

PAYMENT INFORMATION

□ **Insurance-** Co-payment and/or co-insurance is due at the time of service. A **DEPOSIT of $95** is required for any deductible amount. We will bill you for the balance or issue a REFUND IF AN OVERPAYMENT HAS BEEN MADE. If we are unable to verify your benefits, a deposit of **$100** will be required. A REFUND WILL BE ISSUED ONCE THE APPROPRIATE INOFRMATION IS OBTAINED & VERIFIED.

□ **SELF-PAY** - Payment is due at time of service. Discounts are available.

□ **WORKMAN'S COMP INJURY** - If claim is denied for any reason, you will be responsible for the balance. We can submit to your health insurance if claim is denied by BWC. Please provide your health insurance information to assist with this process.

□ **EMPLOYER** – Employer has requested services and is responsible for payment.

PATIENT INFORMATION

LAST NAME	FIRST	MI	SOCIAL SECURITY #
ADDRESS	CITY	STATE	ZIP
HOME PHONE	CELL#	DATE OF BIRTH	SEX □ MALE □FEMALE
□SINGLE □MARRIED □DIVORCED □WIDOWED			
EMPLOYED □YES □NO	EMPLOYER	EMPLOYER PHONE	

PRIMARY INSURANCE INFORMATION			SECONDARY INSURANCE INFORMATION If you are covered by more than 1 insurance plan, we will collect the co-payment with the least amount required.		
INSURANCE COMPANY			INSURANCE COMPANY		
NAME OF POLICY HOLDER	SOCIAL SECURITY #		NAME OF POLICY HOLDER	SOCIAL SECURITY #	
RELATIONSHIP TO PATIENT	□SELF □PARENT □SPOUSE □OTHER		RELATIONSHIP TO PATIENT	□SELF □PARENT □SPOUSE □OTHER	
POLICY HOLDER ADDRESS			POLICY HOLDER ADDRESS		
CITY	STATE	ZIP	CITY	STATE	ZIP
HOME PHONE	CELL #	DATE OF BIRTH	HOME PHONE	CELL #	DATE OF BIRTH
EMPLOYER	EMPLOYER PHONE #		EMPLOYER	EMPLOYER PHONE #	

GUARANTOR INFORMATION **(PLEASE COMPLETE IF PATIENT IS UNDER 18 YEARS OF AGE)**

Parent/legal guardian is responsible for minors. If parents are divorced, Beechmont Urgent Care will not act as a mediator in settling claims/payment issues. The parent that brought the child in for treatment is responsible for payment. Legally, we are not able to bill ex-spouses (regardless of divorce decree).

YOUR RELATIONSHIP TO PATIENT: □PARENT/GUARDIAN □ STEP-PARENT □ OTHER ______________

LAST NAME	FIRST	MI	SOCIAL SECURITY #
ADDRESS, CITY, STATE, ZIP	HOME #	CELL#	DOB

I acknowledge that the above information is correct. I have reviewed a copy of Beechmont Urgent Care's privacy practices and billing policies. I understand that the use of my insurance card is not a guarantee of payment and that I am financially responsible for the services provided. Any overdue balances may be referred to the 3 major credit bureaus. I agree to pay any fees related to the collection of any unpaid balance. I authorize Beechmont Urgent Care to release medical information to any of my physicians, insurance company and/or their authorized representative.

X ______________________________ DATE ____/____/____

Beechmont Urgent Care

Consent to Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- For judicial & administrative proceedings according to specific requirements.

I have been informed by you of *your Notice of Privacy Practices* containing more complete descriptions of the uses and disclosures of my health information. I understand that the Notice of Privacy Practices covers all entities of Beechmont Urgent Care. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Unless you object, we will call to confirm an appointment and / or leave a message, call you regarding your account (at the phone # provided by you), call and / or leave a message regarding treatment and / or test results.

Authorization

I, ______________________________, Date of birth _____________, designate the following person(s) to be able to speak with staff at Beechmont Urgent Care on my behalf about my medical condition or the status of my account. I release Beechmont Urgent Care and its staff from any claim of confidentiality in connection with the release of this information.

Name of Designated Person: ______________________________

Relationship: ______________________ Phone Number: ______________________ Home / Work / Cell (circle one)

Name of Designated Person: ______________________________

Relationship: ______________________ Phone Number: ______________________ Home / Work / Cell (circle one)

☑ I *do not* wish to designate anyone at this time.

Patient Name: ______________________________ DOB: ______________

Patient Signature: ______________________________ Date: ______________

Name of the Patient Representative (or Guardian): ______________________