

**PATIENT REGISTRATION**

Patient’s Name: (First) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Last) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Middle) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Name (nickname): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Sex: **O** *Male* **O** *Female*

Social Security Number: \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital Status:**

*( check box)*

O married

O Single

O widowed

O divorced

O child

**EMPLOYER:**

Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_X \_\_\_\_\_\_\_\_

Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment Status: *(check box)* O full-time O part-time O Disabled O Retired

 O unemployed O self-employed O student

**PARENT / LEGAL GUARDIAN:** *(if patient is under 18 or special needs)*

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_Social Security No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_License No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT:**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To be used for **statistical purposes only.** Answering questions below is ***optional***

 **Race:** *(check box)* O White O American Indian or AK Native O Black or African American

O Asian O Native Hawaiian or Pacific Islander O Patient Declines

**Ethnicity:** *(check box)*O ***not*** Hispanic or Latino O Hispanic or Latino O Patient Declines

**Preferred Language:** *(check box)* OEnglish O Spanish O Russian O German Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Need Translation:** *(check box)* O Yes O No O Unknown

**Primary Insurance**

Insurance Co: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is Patient Subscriber/Policy Holder? O Yes O No

Insured ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Information (***If other than Patient***)

Subscriber/Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

His or Her Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance**

Insurance Co: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is Patient Subscriber/Policy Holder? O Yes O No

Insured ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Information (***If other than Patient***)

Subscriber/Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

His or Her Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization for Release of Information**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_**

Urgent Care at Lake Lucille is authorized to release protected health information about the above named patient to the persons named below. The purpose is to inform the patient or others in keeping with patient’s instructions. ***Any mental health, drug and alcohol treatment or HIV/AIDS related health information will need a separate release form.***

**Person to Receive Information:**  **Description of information to be released:**

Check each person that you Check each that can be given to person on

authorize to receive information. left in the same section.

□ Spouse (***Provide name & phone number***) □ Financial

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Medical

□ Parent (***Provide name & phone number***) □ Financial

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Medical

□ Other (***Provide name, relationship to patient & phone number***) □ Financial

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Medical



**Except to the extent that action has already been taken in reliance upon the authorization, I understand that I may revoke this authorization at any giving time by providing written notice to Urgent Care at Lake Lucille.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name of Patient Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient**

**OFFICE POLICIES**

Thank you for choosing Urgent care at Lake Lucille for your health care needs. Your understanding of and compliance with our office policies is important. Please read our policies below and ask staff any questions you may have.

1. **PROOF OF INSURANCE:** For those patients covered by insurance, we will be happy to extend the ***courtesy*** of billing your insurance company for reimbursement. We will submit your claims and assist you in any way we can to help get your claims processed. Your insurance plan(s) may request information directly from you. Your failure to comply with your insurance plans request in a timely manner may result in your claim being denied and if so, will result in our seeking full reimbursement from you for services rendered; even if we are a participating provider with your plan. ***Your insurance benefit is a contract between you and your insurance plan. It is your responsibility to know your coverage.***
2. **CHANGE OF INFORMATION:** We ask that you notify us whenever there is a change in address, employment, insurance, etc. *It is your responsibility to ensure that we have your correct information and up-to-date copy of your insurance card(s) for yourself and each individual dependent(s). When updating information, please inform office staff of any other accounts that will need updating as well. I.e. spouse or child (children).*
3. **DEDUCTIBLE, COPAY, COINSURANE:** Payment of deductible, copay and/ or coinsurance is expected at time of service. If you are unaware of your payment amounts at the time of service, ***payment in full or a payment of at least 20% will be required upon check out.*** If you fail to provide us with the correct information needed to process your claims, or the information is provided after the “timely filing period”, you will be responsible for the entire cost of the services rendered and immediate payment will be expected.
4. **IN-OFFICE LAB SERVICES:** Please be aware that, when we can, labs will be drawn “in-office” and billed by our office. This allows you to know what services and charges will be billed to you and/or your insurance at the time of service. If you have any questions regarding the service or the charges, ***please discuss with staff before the laboratory tests are completed.*** If you wish to have your labs performed elsewhere, please inform the medical staff before they are drawn. If you are insured with Blue Cross, Medicare and/or Medicaid, you will receive a separate bill from Quest Diagnostics for any labs performed outside of Urgent Care at Lake Lucille.
5. **PROMPT PAY:** Urgent Care at Lake Lucille understand that financial burden that unforeseen medical expenses can place on a patient. Therefore; as a service to our community, we have created a “Prompt Pay” discount for all patients who choose to pay for services in full at the time services are rendered and whom UCLL will not be billing another party for these services. ***This means, a patient will receive discounted office visit of $135.00 (whether you are a new or established patient) and a 20% discount for all procedures, x-ray & laboratory services (Discounted services do not include supplies or oral medications dispensed by our office) when paid at the time services are rendered.***

Urgent Care at Lake Lucille is contracted with Blue Cross, Aetna, Medicare and Medicaid and is required to bill them for all medical services provided. Therefore; **if we are aware of your coverage, we must bill them and cannot offer any prompt-pay discounts.**

If you no longer have a contracted insurance, you will be required to update and sign our verification sheet.

Prompt pay also applies to any insurance company who would like to pay at time of service to receive discounted services. **It does not apply to deductibles with contracted insurance companies.**

**Please initial that you have read and understand the prompt pay policy: \_\_\_\_\_\_\_\_\_**

**WORKERS COMPENSATION:** If you are claiming workers compensation, you must provide us with a copy of your personal insurance card and a current report of injury from your employer, or complete one in office, containing the insurance billing information. If at any time your claim is controverted we can then bill your primary insurance for payment. If you have no other insurance, you will be responsible for any and all services rendered.

**RELEASE OF INFORMATION**

I authorize the release of copies or summaries of my medical record to any health care facility to which I may be transferred or referred. I hereby release Urgent Care at Lake Lucille from all legal liability that may arise from the release of the information requested and provided. A photocopy of this authorization shall be as binding as the original.

**CONSENT TO TREAT**

I, the undersigned, request and authorize Urgent Care at Lake Lucille and all of its physicians, mid-level providers, medical assistants and other qualified personnel to provide any medical/surgical treatment, diagnostic tests and care which the medical provider or designee(s) may deem necessary or beneficial for my health.

I understand that the results of any treatments, tests or care cannot be guaranteed. I also understand that I have the right to refuse any drugs, treatment, or procedures to the extent permitted by law.

I understand that medical, nursing, and other health care personnel in training may be observing and actively participating in my care under the supervision of authorized personnel. I hereby give my consent to such observations and/or participation.

**HIPAA**

By signing below, I have read and agree to abide by all above policies including the HIPAA privacy policy provided separately AND attest that all of the information provided to Urgent Care at Lake Lucille is accurate and current.

Patient / Responsible party name **printed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient / Responsible party **signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_