CareWell
URGENT CARE

PATIENT REGISTRATION FORM

Patient Last Name:	First:	Middle Initial:

Birth Date:	Social Security Number:
Gender: Male Female	Language: Race:
Home Phone:	Ethnicity: ( ) Decline Disclosure
Cell Phone:	Mailing Address:
Email Address:	City: State: Zip Code:
Email Opt Out: Please exclude me from the	Name of Primary Care Physician:
( ) Carewell Better Health Tips ( )Medical Test Results ( )Other	Primary Care Physician Phone #:
Emergency Contact:	Reason for Visit: *(please note if visit is workers' comp. or accident related)*
Relationship:	
Phone:	How Did You Hear About Us?

INSURANCE INFORMATION **PLEASE HAVE YOUR INSURANCE CARD AND PHOTO ID READY FOR SCANNING**

Primary Insurance:		Subscriber Name:	
Policy #:	Group #:		Birth Date:
Address of Subscriber:	City:	State: Zip Code:	Relationship:
Secondary Insurance:		Subscriber Name:	
Policy #:	Group #:		Birth Date:
Address of Subscriber:	City:	State: Zip Code:	Relationship:

FINANCIAL GUARANTOR/RESPONSIBLE PARTY (IF PATIENT IS UNDER 18)

Last Name:	First:	Middle Initial:
Birth Date:	Social Security Number:	
Gender: Male Female	Home Phone:	Cell Phone:
Mailing Address:	City:	State: Zip Code:

Revised: September, 2013

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NOTICE OF PRIVACY POLICY
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) ACKNOWLEDGEMENT

By signing below, you consent to our use and disclosure of your medical information so that CareWell Urgent Care (CWUC) may treat you, seek payment from third parties for such treatment, and generally carry on CWUC's health care operations. You also consent to CWUC's disclosure of your medical information to insurers and providers outside of CWUC when necessary so that these insurers and/or providers may treat you, seek payment for that treatment, and for the purpose of their health care operations. You may refuse all or part of this consent. If you refuse use of your medical information or payment from your insurance company, you will be responsible for payment of your bills. This consent will be valid for the entire duration of treatment by CWUC unless you request the consent be revoked.

PATIENT SIGNATURE: _____ DATE: _____

INSURANCE RELEASE OF INFORMATION

I hereby authorize the office of CWUC to release to my insurance company any necessary information needed to file and expedite payment on my claim. I further assign any benefits payable on my behalf to CWUC. I understand I am financially responsible for any balance not covered by my insurance carrier.

PATIENT SIGNATURE: _____ DATE: _____

PAYMENT POLICY

For Our Contracted Plans:
If your insurance requires you to pay a pre-determined co-payment, deductible, or co-insurance, you will be expected to pay this amount today. We will file your claim with your insurance company's EOB determination of the claim. If your insurance indicates you are responsible for any additional co-pay, deductible or co-insurance, you will be billed and agree to payment of this responsibility.
If You Do Not Have Insurance:
You will be asked to pay $150.00 Visit Fee prior to being seen, and the remaining balance for additional services upon checkout, at the discounted amount. We accept cash, personal checks, and all major credit cards.
Insurance We are Not Contracted With:
IF WE ARE ABLE TO VERIFY YOUR ELIGIBILITY AND IN-NETWORK OR OUT-OF-NETWORK COVERAGE, you will be asked to pay any pre-determined co-payment. We will courtesy file your claim with your insurance carrier and follow the insurance company's EOB determination of the claim. If your insurance indicates you are responsible for any additional co-pay, deductible or co-insurance, you will be billed and agree to payment of this responsibility.

PATIENT SIGNATURE: _____ DATE: _____

I have been advised of my PATIENT RIGHTS and have had an opportunity to read and review my PATIENT RIGHTS.

PATIENT SIGNATURE: _____ _____DATE: _____

Authorization For Release of Medical Records

I hereby authorize/request you CWUC to release confidential information contained in my medical records including but not limited to progress notes, history & physical, radiology, lab, EEG, medication consultation reports, discharge summaries.
I authorize, (with no limits on dates) history of illness, or diagnostic and therapeutic information, including any dependency, HIV, AIDS and/or other communicable diseases. _____ (Initials)
Private Health Information to:
PCP: _____ Phone: _____Fax:_____ Employer: _____Phone: _____Fax :___ ____
Patient: _____ Phone: _____Fax:_____ Guardian: _____ Phone: _____Fax: _____
PATIENT SIGNATURE: _____ DATE:_____

Consent to Treatment

By signing below, you hereby give permission to CareWell Urgent Care (CWUC) for treatment. This consent covers providers, assistants and other healthcare staff as necessary to provide medical services.

PATIENT SIGNATURE_____DATE:_____

Revised: 2/18/14