

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:			Ethnicity: Mailing Address	. ,		
Cen i none.				, .		
Email Address*:			City:		State:	
Emergency Contact:					Zip Code:	
			Name of Primary Care Physi		ian:	
Relationship:						
Phone:			Primary Care Physician Phone #:			
Reason for Visit: (please note if visit is t	workers' comp. or acciden	nt related)				
How Did You Hear About Us?						
INSURANCE INFORM	AATION **		YOUR INSURA! ANNING**	NCE CARD	AND PHOTO ID READY	
Primary Insurance:		<u>1011 502</u>	Subscriber Na	me:		
Policy #: Group #:		Group #:	Birth Date:		ite:	
A.1.1 (0.1 ")	10:		I o	D 1 :	1.	
Address of Subscriber:	City:	State: Zip Code:		Relationship:		
Secondary Insurance:	,		Subscriber Na	me:		
Policy #:		Group #:	F		Birth Date:	
Address of Subscriber:	City:	•	State:	Relation	ship:	
EINIANCIA	CUADAN	TOD /DECDONIC	Zip Code:	E DATTENT	r ic linided 10)	
FINANCIAL GUARAN Last Name:		First:	<i>R/RESPONSIBLE PARTY (IF PATI</i> st:		Middle Initial:	
Birth Date:			Social Security Number:			
Gender: Male Female		Home Phone:			Cell Phone:	
Mailing Address:		City:		State:		
				Zip Code:		
*By providing your e-mail address, you agree to receive communications from CareWell and our Patient satisfaction survey team. You may unsubscribe at any time.					Revised: 11/20/14	



PATIENT CONSENT FORM

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 for 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.

INSURANCE RELEASE OF INFORMATION

By signing below, you 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 RIGHTS

By signing below, you acknowledge that you have been advised of your PATIENT RIGHTS and have had an opportunity to read and review your PATIENT RIGHTS.

FINANCIAL RESPONSIBILITY

I am voluntarily seeking medical treatment and accept full financial responsibility for all charges for the medical care provided to me and/or my family members by the providers and medical staff of CWUC. I understand that payment for services may not be fully covered

by my insurance of	carrier, whether or not C	CWUC is an in net	work provider for my plan.					
	FULL financial response	ibility for services	on and Occupational Med rendered by CareWell Urge fuses to pay for agreed upon	nt Care in the event that	my WC claim is denied,			
Signature	rnature Date							
By signing below,	esults are in or as a cour	o leave messages b	-mail y voicemail or e-mail at my how you are feeling. I undo					
Authorization 1	For Release of Medic	cal Records						
progress notes, hi I authorize, (with	story & physical, radiolo	gy, lab, EEG, med ry of illness, or dia	al information contained in lication consultation reports agnostic and therapeutic info ls)	s, discharge summaries.				
Private Health I		Form	Employee	Dhomo	Form			
			Employer:					
Patient:	Phone:	Fax:	Guardian:	Phone:	Fax:			
		CONSE	NT FOR TREATMEN	<u>'T</u>				

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:



PAYMENT POLICY AND CREDIT/DEBIT CARD AUTHORIZATION

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. We accept cash, personal checks, and all major credit cards.

For Our Contracted Plans:

If your insurance requires you to pay a pre-determined co-payment, you will be expected to pay this amount today. Additionally, you will be asked to put your credit card on file to cover any portion of your bill that is determined to be your responsibility by your insurance carrier.

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. Additionally, you will be asked to put your credit card on file to cover any portion of your bill that is determined to be your responsibility by your insurance carrier.

NO HASSLE PAYMENT METHOD

To provide you with a convenient payment method, we have instituted Credit Card on File.

- 1. Instant refunds of any credit balances
- 2. Medical spend tracking via your online bank and/or credit card statements
- 3. Support of our green initiative by going paperless

Please complete your authorization to bill a major credit or debit card listed below to cover the portion of the bill as determined by your insurance company to be your responsibility. All credit/debit card information will remain absolutely confidential and stored by a secured processor.

Cardholder	name (as sho	wn on c	redit/debit card):		
Card Type: Card: Visa		Debit Card	American Express	Discover	
Signature: _				Date:	
insurance con card and that	npany reimburs I am legally aut	ement or horized to	denial. I guarantee and w	varrant that I am the legal on the with CareWell Urgent Ca	nd all outstanding balances, after cardholder for this credit and/or debit re. I understand that I will not receive
				ayment notifications ar r to collection or receip	nd receipt via email message. If ot.
Email Addre					