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:
Emergency Contact:		Zip Code:
Relationship:	Name of Primary Care Physician:	
Phone:	Primary Care Physician Phone #:	
Reason for Visit: *(please note if visit is workers' comp. or accident related)*		
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:	Relationship:
		Zip Code:	
Secondary Insurance:		Subscriber Name:	
Policy #:	Group #:		Birth Date:
Address of Subscriber:	City:	State:	Relationship:
		Zip Code:	

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:

***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

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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 carrier, whether or not CWUC is an in network provider for my plan.

_____ **Workers Compensation and Occupational Medicine patients ONLY.**
I agree to assume FULL financial responsibility for services rendered by CareWell Urgent Care in the event that my WC claim is denied, my employer refuses to pay on my claim, or my employer refuses to pay for agreed upon services provided to me.

Signature _____ . Date _____.

Authorization to Leave Voice Messages and/or E-mail

By signing below, you authorize CWUC to leave messages by voicemail or e-mail at my home or other phone number provided to give notification that results are in or as a courtesy call to inquire how you are feeling. I understand that no message will be left regarding confidential medical information.

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:_____

CONSENT FOR 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: 12/28/14

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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 shown on credit/debit card): _____

Card Type: Credit Debit
Card: Visa MasterCard American Express Discover

Signature: _____ Date: _____

I hereby authorize CareWell Urgent Care to charge the indicated credit/debit card for any and all outstanding balances, after insurance company reimbursement or denial. I guarantee and warrant that I am the legal cardholder for this credit and/or debit card and that I am legally authorized to enter into this agreement with CareWell Urgent Care. I understand that I will not receive a statement if there is no balance due after processing my credit/debit card for payment.

☐ Check this box to authorize CareWell to email your receipt.

Email Address: _____