



Patient Registration Form

Please present you insurance card at time of check-in.
Settlement of patient financial responsibility is expected at time of service.

TYPE OF VISIT: Insurance (present card at check-in) Self-pay (payment due at time of service)
 On-the-job injury Other _____

Patient Name		
Last:	First:	Middle:
Date of Birth:	Social Security Number:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		
Street Address:		City, State, Zip
Home Phone: <input type="checkbox"/> Preferred	Cell Phone: <input type="checkbox"/> Preferred	Work Phone: <input type="checkbox"/> Preferred
May we leave you a message regarding your care (x-ray, lab results) on your preferred phone? <input type="checkbox"/> Y <input type="checkbox"/> N	Employer:	Occupation:

Emergency Contact:
Phone Number:

Relationship:

How did you hear about us?			
<input type="checkbox"/> Drive-by/signage	<input type="checkbox"/> Phone Book	<input type="checkbox"/> Radio/TV ad	
<input type="checkbox"/> Insurance company director	<input type="checkbox"/> Family/Friend	<input type="checkbox"/> Mailer	<input type="checkbox"/> Other _____

Parent of Guarantor's Name: (We do not see infants under the age of 6 months.) Complete with name of insured if the patient is not responsible for his or her charges today.		
Last:	First:	Middle:
Date of Birth:	Social Security Number:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street Address:		City, State, Zip
Home Phone:	Work Phone:	Employer:

List any medical conditions you have:

Authorization and Release

Authorize for Treatment: I voluntarily consent to the administration and cost of medical and surgical procedures, x-ray, and medications for myself and/or my dependents.

Assignment of Insurance Benefits: I authorize payment directly to this urgent care center for all benefits otherwise payable to me.

Medicare/Medicaid: Due to government regulations Redi Care **DOES NOT** accept Medicare or Medicaid. I understand that my signature acknowledges that I am **NOT** a participant **NOR** eligible for Medicare Benefits due to age or disability.

Guarantee of Payment: Payment for services is due at the time services are rendered for self-pay patients. I understand that I am financially responsible and agree to pay all charges that are not paid or billed to any other third party payer. I understand that I must pay in full at time of service for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance co-pays, coinsurances, and deductibles at time of service. If you are able to verify my insurance at time of service, I will pay in full for services. I understand that refusal to pay my portion can lead to refusal of service in the future. All payments must be made within 30 days of service.

Release of Records: I authorize this urgent care center to release (verbal or in writing) confidential medical information to my primary care physician, medical facility or physicians referred to me by this urgent care center, including my insurance carrier, employer if treatment is related to employment purposes, or other health care operations which may be liable to me or my practitioner(s) for charges for this treatment and for quality management, utilization review, transfer, and follow-up purposes.

Receipt of Privacy Practices: I acknowledge that I have received and read the Notice of Privacy Practices of this urgent care center.

I understand that a copy of this agreement may be used with the same effectiveness as the original.

PATIENT SIGNATURE _____ DATE ____ / ____ / ____

RESPONSIBLE PARTY _____ DATE ____ / ____ / ____