AccessMD URGENT CARE

Patient Registration

Account #
Chart #

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

PATIENT INFORMATION

Last Name	First Name	MI
SSN	DOB	Gender ☐M ☐F
Street		
City	State	Zip
Home Phone	Mobile Phone	
Email	Birthplace	
Primary Care Provider	Pharmacy:	
I give consent to send a copy of my medical record to the PCP listed above ☐Y ☐N		
Preferred Language	Race ☐American Indian or Alaska Native; ☐Asian; ☐Black or African American; ☐Native Hawaiian or Pacific Islander; ☐White	Ethnicity ☐Hispanic or Latino ☐Not Hispanic or Latino
Please explain the reason for your visit today		
Please list any medications you are taking ☐None		
Please list any medication allergies ☐None		

EMERGENCY CONTACT

Contact Name	Relationship	
Street		
City	State	Zip
Home Phone	Mobile Phone	
Best Form of Contact ☐Home Phone; ☐Mobile Phone; ☐Work Phone; ☐Email		
Best Time to Call	Leave Message ☐Y ☐N	

GUARANTOR (responsible party if under 18)

Name	
DOB	SS#
Address	
Home Phone	Mobile Phone

EMPLOYMENT

Employer			
Street			
City		State	Zip
Employer Phone	Employer Fax	Employee Phone	
Occupation		Title	

HOW DID YOU HEAR ABOUT US?

PARTNER/PARENT EMPLOYMENT

☐Partner ☐Parent	Name
Phone	

PRIMARY INSURANCE INFORMATION	SECONDARY INSURANCE
Is the patient covered by insurance? ☐Y ☐N	
Insurance Co	Insurance Co
Plan Name	Plan Name
ID#	ID#
Group #	Group #
Insured Name	Insured Name
Insured SS#	Insured SS#
Relation to Patient	Relation to Patient
Street	Street
City	City
State	State
Zip	Zip
Home Phone	Home Phone
Mobile Phone	Mobile Phone
DOB	DOB
Employer	Employer
Copay Amount	Copay Amount

AUTHORIZATION AND RELEASE

By signing this consent form I acknowledge that I have read, understand, voluntarily consent to and authorize the following:

Authorization of Treatment :

I authorize the administration and cost of all medical and surgical procedures, x-ray, and medication for myself and my dependents.

Guarantee of Payment:

_____ (Initial) Self Pay : I elect to pay for all services rendered in full today. I understand that my insurance will NOT be billed by AccessMD Urgent Care.
_____ (Initial) Insurance – Assignment of Benefits: I authorize payment directly to AccessMD Urgent Care for all benefits otherwise payable to me. I understand that I am financially responsible for all charges not covered by insurance. I authorize AccessMD Urgent Care to submit claims to my insurance carrier as well as medical records required to evaluate these claims for payment. I understand that if my employer is responsible for all or part of this claim, they will receive the necessary medical information required to evaluate these claims for payment.

Receipt of Privacy Practices :

By signing this consent form I acknowledge that a copy of the Notice of Privacy Practices of AccessMD Urgent Care has been offered/is available to me upon request.

Patient Signature _____ Date _____

Responsible Party _____ Date _____

Release of Medical Records :

I authorize AccessMD Urgent Care to release verbally, electronically and/or in writing confidential medical information obtained during the course of my examination and/or treatment to any person or entity including my insurance carrier, employer (if treatment is related to employment), and/or other healthcare provider(s) for purposes of treatment, payment of charges, quality assurance and utilization review. I understand that should I choose not to release my medical records to a specific entity and/or person(s) I must specifically state so in writing for inclusion in my medical record.

Patient Signature _____ Date _____