Patient Registration Form

MedAccess URGENT CARE, PLLC

Personal Information

Last Name	First Name	
Middle Name	Social Security Number	DOB
Marital Status Unmarried	Gender ☐ Male ☐ Female	Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Race ☐ White ☐ Asian ☐ Black/African America ☐ American Indian or Alaskan Native ☐ Native Hawaiian or Pacific Islander	Employer	
Phone ☐ Home ☐ Cell	E-mail	
Mailing Address		Apt #
City	State	Zip

If we need to call your home for any reason and cannot reach you, may we leave a message on your voice mail or with a responsible adult? ☐ Yes ☐ No

By checking "no," I acknowledge that I, the patient/guardian, am fully responsible for contacting MedAccess Ugent Care, PLLC for test results.

Signature: _____ SIGN HERE

Please initial below if it is OK for MedAccess Urgent Care, PLLC to contact you by e-mail. INITIAL HERE _____

Medical Information

Symptoms *(required)*	Primary Care Physician	
Emergency Contact	Phone Number	Relationship

Insurance Information (for policy holder) *Only required if you are not the policy holder.

Last Name	First Name	
Social Security Number	DOB	
Phone	Relationship	Gender ☐ Male ☐ Female
Mailing Address		
City	State	Zip

Guarantor (responsible party) *Only required if you are not the policy holder.

Last Name	First Name	
Social Security Number	DOB	
Phone	Relationship	Gender ☐ Male ☐ Female
Mailing Address		
City	State	Zip

Marketing Information

How did you hear about us? ☐ Billboard ☐ Clinic ☐ Newspaper ☐ Phone Book ☐ Radio ☐ Work ☐ Internet ☐ Doctor ☐ Referral ☐ Friend ☐ Mailer ☐ Relative ☐ TV ☐ Existing Patient ☐ Other: _____

MedAccess Urgent Care, PLLC sends occasional e-mails to its clients including updates on new treatments, seasonal reminders, public services announcements and community events. We are committed to customer service, and we will not clutter your inbox. If you wish to opt-out of these updates, please initial here: _____ INITIAL HERE

Financial Policy

Dear Valued Client,

Thank you for choosing MedAccess Urgent Care, PLLC!

Our facility is contracted and set up to directly bill the following insurances:

- Aetna
- Blue Cross Blue Shield
- Cigna
- Duke Select
- Humana Medicare (Commercial Humana **NOT** Accepted)
- First Health
- Gateway Health
- Medcost
- Medicare
- Tricare
- UMR
- United Healthcare
- Wellpath/Coventry

We do not accept any form of Medicaid or Medicaid HMO. We only accept the insurances listed above. If your insurance is not on the list you will be treated as a self-pay patient.

If your insurance is co-pay based, we will collect a co-pay at check-in for an urgent care visit and bill your insurance for the balance. If you have a deductible, we will file your insurance and you will be billed for the balance.

If we are out of network for your insurance, we will collect payment in full at the time of service. We will bill your insurance company on your behalf and reimburse you for any fees discounted.

If you do not have insurance, we collect a $110 deposit at check-in. At the end of your visit, we calculate and collect for any additional charges. Self-pay costs must be paid, in full, at the time of service and have been greatly discounted.

It is the patient's/guarantor's obligation to provide us with accurate, current insurance information at time of service. Failure to do so will result in the patient/guarantor assuming responsibility for the bill in its entirety.

_____ _____ ***INITIAL HERE***

Initials **Date**

Thank you again for choosing MAUC. Please let us know how we may best serve you. If you have any billing questions, please contact us at 336-330-0400.

FOR INTERNAL USE

Patient Last Name:_____

Record Number:_____

Treatment Consent

CONSENT FOR MEDICAL TREATMENT

I voluntarily present for treatment and consent to my physician and whomever they may designate as their assistant, associate, treating physician, and patient care staff to provide my care. Such care may include, but not limited to, diagnostic procedures. Physiotherapeutic treatment, other treatments and medications, pathologic and radiological evaluations and procedures and considered advisable in my diagnosis, treatment, and course of care. I acknowledge that no guarantee can be made or has been made as to the results of treatments or examinations at MedAccess Urgent Care, PLLC (MAUC).

RELEASE AND USE OF PATIENT INFORMATION

I authorize the release of my medical records, information, treatment and advice, and specific health information to:

1. AN EMPLOYER who requests services (including history, physical, laboratory and diagnostic tests, and screening for the presence of drugs, alcohol, or marijuana)
2. INSURANCE COMPANY or other third party payer and their agents as well as any review organization or government agency for the purpose of determining eligibility, available benefits and obtaining payment for services provided.
3. EDUCATIONAL OR SCIENTIFIC INSTITUTIONS authorized health care professionals in training, internal quality improvement, risk management and legal counsel when it is judged that my ongoing medical care, medical research, quality improvement, healthcare education or science will benefit; for any purpose authorized by law.
4. TREATING PHYSICIANS on staff at MAUC; to another health care facility upon direct transfer and to my attending consulting, referring and/or primary care physicians for follow up care. I understand that if I refuse to authorize access to my records for coordination of care, my treatment could be adversely affected.

I understand this information concerning medical care, advice or treatment may include history and physical/diagnosis/laboratory and diagnostic testing/specific information concerning alcohol abuse/mental health/drug abuse/human immune-deficiency virus/hepatitis/ or other infectious diseases. I understand that I have the right to revoke this authorization. If my revocation prevents payment or reduces payment for services received, I become responsible for payment.

ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT GUARANTEE

In consideration of services provided by MAUC, I hereby assign and transfer to MAUC any and all rights, which I have against insurance companies, government agencies, or third party payers, for payment of charges for services provided by MAUC to me or to one of my dependents. I understand that I am responsible for and will pay the portion of my bill not covered by insurance companies, government agencies, or third party payers. In consideration of services to be provided, I agree to pay MAUC in accordance with the regular rates and terms of MAUC. I further agree to pay the account in full upon receipt of my billing statement unless payment arrangements are made with MAUC. I authorize said payments to be applied to any unpaid MAUC balance for which I am responsible.

I give consent, authorize release, and assign benefits to MACU: _____

Patient/Guarantor Signature

SIGN HERE

RECEIPT OF HIPAA PRIVACY NOTICE

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how MAUC may use and disclose my protected health information. I understand that MAUC reserves the right to change the privacy notice and that a copy of the revised notice will be available to me.

SIGN HERE

_____

Patient/Guarantor Signature

AUTHORIZATION TO RELEASE MEDICAL INFORMATION (VERBAL AND COPIES) TO MEMBERS OF YOUR FAMILY OR OTHER INDIVIDUALS

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1966, in order for your physician or the staff of Roxboro MAUC to give copies of and/or discuss your condition/exams/procedures/x-rays with members of your family or other individuals that you designate other than your primary care doctor or specialist, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived. I authorize MAUC to release any and all information (including verbal information, copies of x-rays and medical paperwork) concerning my medical care to the following individuals:

Name (please print)	Relationship	Phone Number
Name (please print)	Relationship	Phone Number

☐ I **DO NOT** authorize MAUC to release any information concerning my care to any individual.

☐ I authorize MAUC to leave a detailed message on the following authorized phone number: _____

☐ I **DO NOT** authorize MAUC to leave a detailed message on my answering machine or voicemail. I acknowledge that by choosing this option that I, that Patient, assume full responsibility for contacting MAUC for the results of all testing.

SIGN HERE

Your signature **Date**

AUTHORIZATION TO DISCUSS FINANCIAL INFORMATION

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1966, we must obtain your authorization to discuss financial information with members of your family or other individuals that you designate other than insurance companies or third party payers and their agents.

I **authorize MedAccess Urgent Care, PLLC** to verbally discuss financial information with:

Name (please print)	Relationship	Phone Number
Name (please print)	Relationship	Phone Number

SIGN HERE

Your Signature **Date**

FOR INTERNAL USE

Patient Last Name:_____

Record Number:_____