Urgent Care
Washington Regional

PATIENT INFORMATION

_____ _____ _____ _____ ____/____/_____
Last Name First Name Middle Initial Suffix DOB MM/DD/YYYY

Gender ☐ Male ☐ Female _____-____-_____ (_____) _____-_____ (_____) _____-_____
Social Security Number Home Phone Mobile Phone

_____ _____
Address Apartment Number

_____ _____ _____-_____ _____
City State Zip Country

_____@_____ _____
Email Preferred Language

Can this email be used for patient portal? ☐ Yes ☐ No

Primary Care Physician (PCP) _____

Race

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ White
☐ Native Hawaiian or Other Pacific Islander

Ethnicity

☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino

_____ _____ (_____) _____-_____
Pharmacy Name ***Pharmacy Phone***

REASON FOR VISIT

_____
_____

EMERGENCY CONTACT

_____ _____ _____ _____ _____
Last Name First Name Middle Initial Suffix Relationship

(_____) _____-_____ (_____) _____-_____
Home Phone Mobile Phone

RESPONSIBLE PARTY/GUARANTOR

☐ Same as Patient ☐ Other (Fill out below information)

_____ _____ _____ _____ ____/____/_____
Last Name First Name Middle Initial Suffix DOB MM/DD/YYYY

Gender ☐ Male ☐ Female _____-____-_____ (_____) _____-_____ (_____) _____-_____
Social Security Number

_____ _____
Address Apartment Number

_____ _____ _____-_____ _____
City State Zip Country

_____@_____ _____
Email Relationship

Urgent Care
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INSURANCE INFORMATION

Primary Insurance

_____ _____
Insurance Company Insurance Plan

_____ _____
Address Suite Number

_____ _____ _____-_____
City State Zip

(_____) _____-_____ _____ (_____) _____-_____
Phone Extension Fax

_____ _____
Insurance Number/Policy Number/Subscriber ID Group Number

____/____/_____ _____
Effective Date MM/DD/YYYY Insured Relationship to Patient

_____ _____ _____ _____ ____/____/_____
Insured Last Name First Name Middle Initial Suffix DOB MM/DD/YYYY

Gender ☐Male ☐Female (_____) _____-_____ (_____) _____-_____
Home Phone Mobile Phone

_____
Employer

Secondary Insurance

_____ _____
Insurance Company Insurance Plan

_____ _____
Address Suite Number

_____ _____ _____-_____
City State Zip

(_____) _____-_____ _____ (_____) _____-_____
Phone Extension Fax

_____ _____
Insurance Number/Policy Number/Subscriber ID Group Number

____/____/_____ _____
Effective Date MM/DD/YYYY Insured Relationship to Patient

_____ _____ _____ _____ ____/____/_____
Insured Last Name First Name Middle Initial Suffix DOB MM/DD/YYYY

Gender ☐Male ☐Female (_____) _____-_____ (_____) _____-_____
Home Phone Mobile Phone

_____
Employer

Patient Financial Responsibility and Consent for Treatment

Urgent Care
Washington Regional

PATIENT INFORMATION

_____	_____	_____	_____	____/____/_____
Last Name	First Name	Middle Initial	Suffix	DOB: MM/DD/YYYY

I hereby give my consent and authorize Washington Regional Urgent Care Providers to perform reasonable and necessary medical examinations, including testing. I consent to permit the Provider to treat any medical condition provided that the health care Provider has explained my condition to me, the treatment procedures and alternative methods of treating my condition. I understand this Consent Form is an effort to obtain my permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

I authorize the Provider to perform any additional or different treatment, which is thought necessary should, during treatment, a condition be discovered which was not known previously. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s) being performed or services provided.

PAYMENT, TREATMENT AND DATA AGREEMENT

- I understand I am responsible for any amounts not covered by my insurer, including charges and deductibles. If my insurance carrier denies any part of my claim, I am responsible for the entire remaining balance.
- I authorize a photocopy of this statement to serve as the original and the use of this signature on all insurance submissions.
- I am personally responsible for providing accurate and current insurance information.
- I authorize release of all information necessary to secure payment of benefits.
- I understand that any services not provided directly by Washington Regional Urgent Care (Lab results, diagnostic services) are a separate charge and those charges will be billed separately by the provider of such services.
- I authorize examination and treatment for this and all following associated medical visits.
- I understand this Consent will remain fully effective until it is revoked in writing. I have the right at any time to discontinue services.

I certify that the above information is true and correct. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its content.

_____	____/____/_____
Patient or Guardian Signature	Date MM/DD/YYYY

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SecurePayEnrollmentForm

By signing this form you give Washington Regional Urgent Care permission to charge your Credit/Debit/HSA card indicated below up to $300 for any amount not paid by insurance. This authorization applies to each balance prior to or after the date of this authorization. Prior to charging your account, you will receive a statement notifying you of the amount due. Following the receipt of the statement, you will have 2 weeks from the statement date to contact Washington Regional Urgent Care if you would like to make alternative arrangements for payment. *Services to Include: Office visit and any related services including, but not limited to, Labs, x-rays, injections, any additional ancillaries, etc.*

Please complete the information below:

I_____authorize_____(Center Name) to keep my signature securely on file and to charge my Credit/Debit/HSA card indicated below up to $300 for any amount not paid by insurance.

Account Type: Visa MasterCard AMEX Discover

Cardholder Name: _____

Credit Card # (Last 4): _____

Cardholder Address:_____
(If different than patient)

OFFICE USE ONLY

Patient ID:_____

SIGNATURE_____ DATE _____

I authorize the above named business to charge the Credit/Debit/HSA card indicated in this authorization form according to the terms outlined above. I certify that I am an authorized user of this credit card. This authorization expires one year after the above date.

HIPAA AUTHORIZATION

Patient Name:_____ **DOB:** ____/____/____

CHOOSE ONE:

⎦ **I DO NOT authorize Washington Regional Urgent Care to release my medical and billing information to anyone other than myself.**

OR

⎦ **I authorize Washington Regional Urgent Care to release my medical and billing information to the individuals listed below:**

RELATIONSHIP		NAME OF DESIGNATED PERSON	PHONE
SPOUSE	⎦ YES □ NO	_____ Please Print	_____
CHILDREN	⎦ YES □ NO	_____ Please Print	_____
IN-LAWS	⎦ YES□ NO	_____ Please Print	_____
CAREGIVERS	⎦ YES□ NO	_____ Please Print	_____
PARENTS	⎦ YES□ NO	_____ Please Print	_____
OTHERS:	⎦ YES □ NO	_____ Please Print	_____

I authorize Washington Regional Urgent Care to leave information on my voicemail: HOME: □YES □NO CELL: □YES □NO WORK: □ YES □ NO

I authorize Washington Regional Urgent Care to leave notice of breach on my e-mail: BREACH NOTIFICATION ONLY: YES NO

The HIPAA privacy rule permits health care providers to communicate with patients regarding their health care, including protected health information (PHI) and billing information. This includes communicating with the patient through mail, phone, encrypted e-mail, fax or some other manner.

I understand that Washington Regional Urgent Care is permitted by the HIPAA privacy rule to leave information regarding my appointment, including, the date and time, on any phone number(s) provided. Washington Regional Urgent Care may request a return phone call to our office by leaving a message or when speaking to any individual that answers the phone. If I only want confidential communication between myself and Sherwood Urgent Care I must provide written notice to these entities on a form provided upon my request.

I understand that it is my responsibility to keep Washington Regional Urgent Care informed of any changes to this information and that I may revoke this authorization at any time by written notice to these entities on a form provided upon my request.

_____ _____

Signature of Patient or Personal Representative (Legal Guardian) Date

_____ _____

MINOR Patient ONLY - Print Name of Personal Representative (Legal Guardian) Date

Washington Regional Urgent Care
Notice of Privacy Practices
Acknowledgement

Patient Name:_____ **DOB:**____/____/____

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will only be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly
- Obtain payment from third-party payers or responsible parties
- Conduct the healthcare operations of health care education, quality assessments and patient satisfaction surveys

A copy of the Washington Regional Urgent Care *Notice of Privacy Practices* was made available to me. It contains a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact Washington Regional Urgent Care at any time to obtain a current copy of the *Notice of Privacy Practices*.

_____ _____

Signature of Patient or Personal representative **Date**

URGENT TEAM USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the *Notice of Privacy Practices* Acknowledgement but was unable to do so as documented below:

Date:	Initials:	Reason:

Urgent Care
Washington Regional

New Patients – we need your feedback!

How Did You Hear About Us?

Please check the one box that best describes how you heard about us.

ONLINE

- ☐ Facebook
- ☐ Promotional/Educational Email
- ☐ Search Engine (Google, Bing, etc.)
- ☐ Website Ad

COMMUNITY

- ☐ Drove by/Building signs
- ☐ Event/Sponsorship
- ☐ Friends/Family Referral
- ☐ Physician/Pharmacy Referral

PRINT/MEDIA

- ☐ Billboard
- ☐ Brochures/Flyer
- ☐ Mail/Postcard
- ☐ Newspaper/Magazine
- ☐ Radio

☐ **OTHER** (Describe) _____

Thank you, we will use this information to better understand the community and how people find us. We are here to serve you and your family.