

These forms are for new patients only. Completing this form does not reserve an appointment or save your spot in line. After completing the forms, please print and bring with you to your center visit.

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
 Native Hawaiian or Other Pacific Islander White
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 ____/____/____
Gender Male Female _____
Social Security Number (____) _____ - _____ (____) _____ - _____
Address Apartment Number

City State Zip Country

Email Relationship

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 <input type="checkbox"/> Male <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	() -		() -		
			Home Phone	Mobile Phone	
Employer					

Patient Financial Responsibility and Consent for Treatment



PATIENT INFORMATION

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

I hereby give my consent and authorize Urgent Team 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 Urgent Team (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



Secure Pay Enrollment Form

By signing this form you give Urgent Team permission to charge your Credit/Debit/HSA card indicated below up to \$200 for any amount not paid by insurance. This authorization applies to each balance effective 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 Urgent Team 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 \$200 for any amount not paid by insurance.

Account Type: Visa MasterCard AMEX Discover	
Cardholder Name: _____	<u>OFFICE USE ONLY</u>
Credit Card # (Last 4): _____	Patient ID: _____
Cardholder Address: _____ (If different than patient)	

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 Urgent Team to release my medical and billing information to anyone other than myself.

OR

I authorize Urgent Team to release my medical and billing information to the individuals listed below:

<u>RELATIONSHIP</u>		<u>NAME OF DESIGNATED PERSON</u>	<u>PHONE</u>
SPOUSE	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	_____ Please Print	_____
CHILDREN	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	_____ Please Print	_____
IN-LAWS	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	_____ Please Print	_____
CAREGIVERS	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	_____ Please Print	_____
PARENTS	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	_____ Please Print	_____
OTHERS:		_____ Please Print	_____

I authorize Urgent Team to leave information on my voicemail:

HOME: YES NO CELL: YES NO WORK: YES NO

I authorize Urgent Team 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 Urgent Team is permitted by the HIPAA privacy rule to leave information regarding my appointment, including, the date and time, on any phone number(s) provided. Urgent Team Holdings, Inc. 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 Urgent Team I must provide written notice to these entities on a form provided upon my request.

I understand that it is my responsibility to keep Urgent Team 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

Urgent Team
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 Urgent Team *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 Urgent Team 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:
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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.