urgent team
FAMILY & URGENT CARE

Patient Registration

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 ____ DOB MM/DD/YYYY ____/____/________

Gender ☐ Male ☐Female

Social Security Number ______-_____-________

(______) ______-________ (______) ______-________

Address ____________________ Apartment Number ____________

City ____________ State ______ Zip ________-______ Country ____________

Email ____________@____________ Relationship ____________

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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

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 $300 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 $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 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:**

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:		________________ 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:

Revised
08/14/2018

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FAMILY & URGENT CARE

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.