

Patient Registration Form

Patient Information

Name: _____ Male Female
 DOB: _____
 Mailing Address: _____ Apt #: _____
 City, State, Zip: _____
 Mobile Phone: _____
 Personal Email: _____

Primary Care Physician (PCP): _____
 Preferred Pharmacy: _____
 Address: _____
 City/State/Zip: _____
 Best Form of Contact: Mobile Email Mail _____
 Best Time to Call: _____ May we leave a message? Yes No

Race

- American Indian or Alaska Native White
 Asian Declined to Specify
 Black or African American Other
 Native Hawaiian/Other Pacific Islander

In order for us to service your account or collect any amounts owed to us, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which may result in additional charges from your phone carrier. We may also contact you by sending an email using the email address you have provided.

By initialing, I acknowledge that I have read this disclosure and agree that you may contact me as described above.

 PLEASE INITIAL

Emergency Contact

This person will be contacted in emergencies and allowed to receive information about your medical treatment.

Name: _____ Male Female Relationship: _____ Mobile Phone: _____

Financial Responsibility

Check if same as patient information. If not, please complete the entire section.

Name: _____ Male Female Relationship: _____
 DOB: _____ Phone: _____

Insurance Information

Check if same as patient information. If not, please complete the entire section.

Primary Insurance: _____ Secondary Insurance: _____
 Subscriber #: _____ Subscriber #: _____
 Subscriber Name: _____ Subscriber Name: _____
 DOB: _____ Relationship: _____ DOB: _____ Relationship: _____

Consent for Treatment/Acknowledgement of Privacy Practices/Acknowledgement of Financial Responsibility

I, the undersigned, consent to the care and treatment by the attending Physician, his/her associates or assistants and acknowledge that no guarantees have been made as to the effect of such treatment.

I have reviewed the Notice of Privacy Practices as provided at registration and understand that I may request a copy of the policy at any time.

I acknowledge full financial responsibility to any services received and I understand that the payment of charges incurred in this office is due at the time of service. I also understand that the charges not covered by insurance remain my responsibility. In the event that my account is turned over to a collection agency, I agree to pay all late fees, costs of collection fees and/or Attorney's fees and all court costs, if any. I understand that any services not provided directly by Baptist Health Urgent Care (Lab results, diagnostic services) are a separate charge and those charges will be billed separately by the provider of such services.

 Signature (Patient/Guardian)

 Date:



Baptist Health

URGENT CARE

An Affiliate of Urgent Team

Secure Pay Enrollment Form

By signing this form you give Baptist Health 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 Baptist Health 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: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> AMEX <input type="checkbox"/> Discover | OFFICE USE ONLY: |
| Cardholder Name: _____ | <input type="text"/> |
| Credit Card # (Last 4): _____ | PATIENT ID: |
| Cardholder Address: _____ <i>(If different than patient)</i> | |

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.