UrgentCare
New Smyrna Beach | Ormond Beach

PATIENT RESISTRATION FORM

LAST NAME: _____ **FIRST NAME:** _____ **MI:** _____
PRIMARY ADDRESS:_____ **APT/UNIT/LOT#:**_____
CITY: _____ **STATE**_____ **ZIP CODE:** _____
HOME PHONE #_____ **CELL PHONE #** _____
DATE OF DATE OF BIRTH _____ **MALE** ☐ **FEMALE** ☐ **PREFERRED LANUAGE** _____
SOCIAL SECURITY: _____ **EMAIL ADDRESS:** _____
MARTIAL STATUS: ☐ **SINGLE** ☐ **MARRIED** ☐ **DIVORCED** ☐ **LEGALLY SEPARATED** ☐ **WIDOWED**
RACE: _____ **ETHNICITY: NON HISPANIC OR LANTINO** _____ **HISPANIC OR LANTINO** _____ **PATIENT DECLINES** _____
HOW DID YOU HEAR ABOUT US?

POLICY HOLDER – ONLY IF NOT PATIENT:

NAME: _____ DOB: _____ SS# _____
ADDRESS: _____
PHONE NUMBER: _____ CELL PHONE: _____

EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____
HOME NUMBER: _____ WORK NUMBER: _____

AUTHORIZATION FOR RELEASE OF PERSONAL MEDICAL INFORMATION

I understand, as outlined in the HIPAA Notice of Patient Privacy Practices, my personal medical information will only be released as it pertains to my medical treatment, payment of charges, or procedure of the practice. The practice is authorized to release my personal medical information to the following individual(s).
NAME: _____ RELATIONSHIP: _____
NAME: _____ RELATIONSHIP: _____

PRIMARY CARE PHYSICIAN
DR._____

LOCAL PHARMACY NAME: _____
ADDRESS/INTERSECTION: _____

I understand that copies of my medical visits will be faxed to the physician upon request.

I confirm that all the above information is correct to the best of my knowledge, and authorize the release of medical information to the individuals I have noted above.

SIGNATURE: X _____ **DATE:** _____

***** INSURANCE PATIENTS – PLEASE READ AND SIGN THE FIRST 3 SIGNATURES OF THE BACK OF THIS FORM**
***** NON-INSURANCE PATIENTS – PLEASE READ AND SIGN ALL 4 SIGNATURES OF THE BACK OF THIS FORM**

ASSIGNMENT AND RELEASE: I authorize the release of any medical information necessary to process my insurance claim. I authorize and request payment of medical benefits directly to my provider. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I understand and agree that, regardless of my insurance status**, I am responsible for any balance of my account.** It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment. Services that are performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow New Smyrna Beach Urgent Care, LLC to use and disclose my protected health information to any credit card entity, bank, or financing company when such disclosure is necessary to process payment.

PATIENT/GUARANTOR SIGNATURE: X_____ **DATE:** _____

CONSENT FOR TREATMENT: I hereby give consent to the provider on duty at NSB/OB Urgent Care to render medical evaluation, treatment, perform diagnostic testing, and procedures according to the provider's discretion. I understand that no guarantee will be made as to the result of examination and/or treatment.

SIGNATURE: X_____ **DATE**: _____

ACKNOWLEDGEMENT OF HIPAA/PRIVACY COMPLIANCE: I have been advised of the office's HIPAA/PRIVACY policies and guidelines. I understand that I will be provided a copy of the policies and guidelines upon request.

_____ _____ _____

PATIENT/LEGAL REPRESENTATIVE OR GUARANTOR SIGNATURE **NSB/OB URGENT CARE WITNESS** **DATE**

NON – INSURANCE SELF PAY PATIENTS: NSB Urgent Care requires *payment* ***in full, due at check-in****, for all self pay patients.* We do not balance bill. I understand I will not be filing to an insurance carrier. **PAYMENT IS DUE BEFORE SERVICES ARE RENDERED. ANY CHARGES ABOVE THE OFFICE VISIT WILL BE AN EXTRA CHARGE.** This includes, but not limited to; Removal of any Foreign Body, Respiratory Testing, Inhalation Therapy, Injections of any kind, Laceration Repairs, IV Infusion Therapy, Skin Debridement, I&D Abscess, Splinting, In House Laboratory Testing, Outside Laboratory Testing, ETC

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