

PATIENT REGISTRATION

Patient Name (Last) _____ First _____ Int. _____

Address: _____ Apt.# _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Sex: M F Date of Birth: _____

Patient Social Security # _____ Marital Status: M ___ S ___ D ___ W ___

Patient Employer: _____ Address: _____

Occupation: _____ Primary Language: _____

Primary Care Physician: _____

Policy Holder Name: _____ Relationship to patient: _____

Responsible Party Social Security #: _____ Date of Birth: _____

Primary Insurance: _____ Secondary Insurance _____

EMERGENCY CONTACT: _____ **PHONE #:** _____

Where did you hear about Urgent Care Associates? _____

Were you injured on the job? Yes ___ No ___ Date of Injury: _____

I understand and agree that I am obligating myself to pay my account based upon the regular rates of Urgent Care Associates for services provided at Urgent Care Associates.

- ♦ All charges are due at the time of service.
- ♦ In the event I am entitled to medical benefits of any type, those benefits are assigned to Urgent Care Associates for application to my bill.
- ♦ Patients eligible for Medicare authorize Urgent Care Associates to bill and collect from Medicare directly.
- ♦ Urgent Care Associates may not be contracted with my insurance company. If this is the case, Urgent Care Associates will bill my insurance for me, but I will be responsible for any charges not covered by my health insurance/Medicare, including copayments, deductibles and coinsurance.
- ♦ Should the account be referred for collection, then I agree to pay, in addition to my outstanding accounts, any reasonable collection expenses, including court costs and attorney fees.
- ♦ I also understand that the charges listed are an estimate of the actual costs incurred.

I have read the above Agreements and fully understand.

SIGNATURE _____ **Relationship to patient** _____

Today's Date _____ **Witness** _____