Medical Urgent Care
3006 Glenmore Ave Suite A
Cincinnati, OH 45238
(513) 661-0555

PATIENT REGISTRATION FORM

PATIENT INFORMATION				Guarantor/Responsible Party		
PATIENT NAME (First, MI, Last)	Date of Birth			Name	Relationship	DOB
ADDRESS (Street, Apt#)				STREET (If Different than Patient's)		
City	State	ZIP		CITY	STATE	ZIP
SOCIAL SECURITY NUMBER	PHONE			SOCIAL SECURITY NUMBER	PHONE	
MARITAL STATUS ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Single	**Reasons for visit:** ❑ Illness/Injury ❑ Work relate ❑ Auto accident ❑ Physical (Adult) ❑ Physical(Sports) ❑ Physical (Child 17 an d under) **Sex** ❑ Female ❑ Male			PLEASE MAKE SURE YOU FILL ALL OF THE INSURANCE INFORMATION BELOW IF INSURED, AND PROVIDE YOU CURRENT INSURANCE CARD AND ID TO THE FRONT DESK.		

Primary Insurance Information				Secondary Insurance Information			
Name of Insurance Company	Policy #			Name of Insurance Company	Policy #		
Policy Holder Name	D.O.B			Policy Holder Name	D.O.B		
Relationship to Patient	Social Security #			Relationship to Patient	Social Security #		
ADDRESS (if different than above)	STATE	ZIP		ADDRESS (if different than above)	STATE	ZIP	
CITY	TELEPHONE (Emergency)			CITY	TELEPHONE		

Medical Urgent Care, the physician or their representative is hereby authorized to give my insurance company or its representative, any and all information they have regarding me or my dependent's condition when under observation or treatment by them including history obtained, diagnosis and treatment. A photocopy of my signature may be used. I hereby assign the benefits payable under my insurance to Medical Urgent Care.

LEGAL SIGNATURE _____ DATE _____

PHARMACY INFORMATION

PHARMACY NAME: _____
PHARMACY LOCATION: _____
PHARMACY PHONE #:_____

STATEMENT TO PERMIT PAYMENTS OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS AND PATIENT

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

I hereby authorize Urgent Care, the physician or their representative to release any medical information pertaining to their services and to submit to my insurance company(s) a claim form and that the carrier may issue payment directly to Urgent Care for services rendered within the next twelve months.

Initial_____

Authorization Statement- I hereby authorize my insurance carrier to pay benefits directly to the physician whose name appears on this statement, realizing I am responsible to pay non-covered services; and hereby authorize the release of any medical information necessary for medical claims to an authorized insurance carrier. I understand that this release may include medical records of treatment for physical and/or emotional illness, including treatment of alcohol or drug abuse. I also understand that HIV, AIDS, or AIDS related information may be released.

Initial_____

Beneficiary's Agreement- I have been notified by my physician/ supplier that any office visit not paid by Insurance, Medicare, and Medicaid are my responsibility to pay. Injections are not covered by Medicaid. These are due at the time they are given unless other arrangements have been made.

Initial_____

I hereby authorize Medical Urgent Care to provide treatment for the illness or injury for which this visit is being made. I understand that I am responsible for payment of all charges per the terms outlined in the Financial Responsibility Agreement.

Sign:_____ Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I,_____have received a copy of this office's Notice of Privacy Practices.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our notice of Privacy Practices, but acknowledgement could not be obtained because:

- ○ Individual refused to sign.
- ○ Communication barriers prohibited obtaining the acknowledgement.
- ○ An emergency situation prevented us from obtaining acknowledgement.
- ○ Other (Please Specify). _____