PATIENT REGISTRATION FORM

Date of Visit: ____ /____ /____

Reason for Visit: ___________________

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Sex: ❑M ❑F	Marital Status (circle one): S / M / D / Separated / W
Date of Birth: / /	Phone Number: Parent's if Patient under 18		Parent's Name if Patient under 18	
Mailing Address:	Apt #		E-mail Address: By providing, you consent to receive communication regarding your care.	
City/State/Zip:			Patient Occupation or Student:	

Race: ❑White ❑Hispanic ❑Black or African American ❑Asian ❑American Indian or Alaska Native		Ethnicity: ❑Hispanic/Latino ❑Not Hispanic/Latino	Preferred Language: ❑English ❑Spanish
Preferred Pharmacy Name:	Pharmacy Location:	Primary Care Provider:	PCP Phone:

Please tell us how you learned of our service or whom we may thank:

❑Drive By ❑Internet ❑Billboard ❑Mailer ❑Pharmacy ❑Doctor:________ ❑Friend/Family: __________ ❑Been here before

INSURANCE INFORMATION

Accident Related? Is this visit due to a work or auto accident? ❑ Yes ❑ No If yes, please notify Front Desk

Please indicate primary insurance: (please indicate *secondary* on the back of this form)

❑Aetna ❑Ambetter ❑Blue Cross Blue Shield ❑Cigna ❑Humana ❑Medicare ❑Tricare ❑United Healthcare ❑________ ❑Self Pay

Subscriber's Last Name: *if not patient*	Subscriber's First Name:	Subscriber's Birth Date: / /	
Member ID Number:	Group Number:	Patient's relationship to subscriber: ❑Self ❑Spouse ❑Child ❑Other:_______	

Assignment of Benefits: I hereby authorize MY Urgent Care Clinic to bill my insurance for services rendered and authorize payment directly to MY Urgent Care Clinic for medical benefits otherwise payable to me; I authorize my insurance company to disclose to MY Urgent Care Clinic information regarding my insurance coverage; I authorize MY Urgent Care Clinic to release and receive information necessary to expedite insurance claims. I understand that I am responsible for paying my copay and/or deductible according to my insurance contract at the time of service.

Authorization for Release of Medical Records: I authorize MY Urgent Care Clinic to release my medical information including diagnosis, x-ray, EKG, test results, report and records for the following purposes: diagnostic, insurance, legal, continuity of care, and medical treatment.

Consent & Authorization to Treat: I have the right to consent to medical or surgical treatment. As an adult or legal guardian, I agree to permit the clinical staff at MY Urgent Care Clinic to provide medical care to myself, my child, or the patient I represent, as applicable. I voluntarily authorize and consent to medical care, treatment, diagnostic testing that providers at MY Urgent Care Clinic believe are necessary.

By signing below, I acknowledge that I have read and fully understand the policies above ***and the additional patient authorizations on the back of this page.*** I understand that this document will be in effect until I withdraw my consent by contacting My Urgent Care Clinic in writing at: 910 River Road, Suite 101, Boerne, TX 78006.

______________________________ Patient Signature

__________________ Patient Date of Birth

__________________ Today's Date

OR

______________________________ Parent/Guardian Name (print)

__________________ Parent/Guardian Date of Birth

______________________________ Parent/Guardian Signature

__________________ Today's Date

PLEASE TURN PAGE OVER

for secondary insurance and additional patient authorizations

SECONDARY INSURANCE INFORMATION

If applicable

Please indicate secondary insurance:

❑Aetna ❑Ambetter ❑Blue Cross Blue Shield ❑Cigna ❑Humana ❑Medicare ❑Tricare ❑United Healthcare ❑________ ❑Self Pay

Subscriber's Last Name: *if not patient*	Subscriber's First Name:	Subscriber's Birth Date: / /	

Member ID Number:	Group Number:	Patient's relationship to subscriber: ❑Self ❑Spouse ❑Child ❑Other:_______

ADDITIONAL PATIENT AUTHORIZATIONS

Financial Policy: I acknowledge that I have had the opportunity to review the MY Urgent Care Clinic Financial Policy and agree to comply.

Financial Responsibility: I understand that I am responsible for payment on my account. Payment is expected at time of service.

Insurance Coverage: I understand that I am responsible to provide MY Urgent Care Clinic with my current insurance coverage information and present my current insurance card at every visit. I will be responsible for paying any balance due as a result of not providing my most current insurance information. I understand that My Urgent Care Clinic will not retroactively file claims due to my failure to provide current insurance information.

Privacy Policy: I acknowledge that I have had the opportunity to review with My Urgent Care Clinic's Privacy Policy and agree to comply.

Additional Authorization and Release of Medical Records: I authorize MY Urgent Care Clinic to release my medical information including diagnosis, x-ray, EKG, test results, report and records to the following person(s) (ie. caregiver, family member) on my behalf:

Name:_____________________ Date of Birth:__________ Phone:____________ Relationship:_____________

Name:_____________________ Date of Birth:__________ Phone:____________ Relationship:_____________