Forest Urgent Care
10-11 49th AVENUE - LONG ISLAND CITY, NY 11101
Tel: 347-318-5488
Fax: 718-729-3161

PATIENT INFORMATION - PLEASE PRINT

Last Name: _____ First Name: _____ Phone Number: _____

Address: _____ Apt No: _____ City: _____ State: _____ Zip Code: _____

Email Address: _____ Date of Birth (mm/dd/yyyy)_____/_____/_____

Sex:_____ Marital Status:_____ Patients Social Security#_____-_____-_____

Employer: _____ Occupation _____

Employee Type: (please select)
( ) Retired
( ) Employed Full time
( ) Employed Part time
( ) Not Employed

Students Type: (please select)
( ) Student Full time
( ) Student Part Time
( ) Not Student

Pharmacy information

Name of the Pharmacy: _____

Address: _____ City_____ State_____ Zip Code_____

Phone Number :_____

Emergency Contact Information

Name of Emergency Contact_____ Relationship:_____

Address:_____ City _____ State _____ Zip Code _____

Phone number:_____

Insurance Information

Primary Insurance # 1:_____

Employer :_____ Insured Name:_____

Address:_____ **(if NOT same as patient)**

Policy Number :_____ Insured's Social Security #_____-_____-_____

Group Number :_____ Sex:_____ Marital Status:_____

Copayment Amount $_____ Relationship to Patient :_____

Is A Referral Necessary : ( )Yes ( ) No Date of Birth (mm/dd/yyyy)_____/_____/_____

Secondary Insurance # 2:_____

Employer :_____ Insured Name:_____

Address:_____ (if not same as patient)

Policy Number :_____ Insured's Social Security #_____-_____-_____

Group Number :_____ Race:_____Sex:_____ Marital Status:_____

Copayment Amount $_____ Relationship to Patient :_____

Is A Referral Necessary : ( )Yes ( ) No Date of Birth (mm/dd/yyyy)_____/_____/_____

I, the undersigned certify that I (or my dependent) have insurance coverage with insurance companies as listed on page 3 and assign directly to Forest Urgent Care Center all Insurance benefits if any, otherwise payable to me for service rendered. I understand that I am financially responsible whether or not paid by insurance. I hereby authorize the doctors to release all information necessary to process my insurance claims and secure the payment of benefits directly to Forest Urgent Care Center. I authorize the use of this signature on all insurance submissions. I understand that copayments or the office visit is due prior to seeing the physician.

_____ _____ _____

Patient or Responsible Party Signature | Relationship if not Patient | Date

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Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you . The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payments and health care operations. You have right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already make in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1966 (HIPPA).

The patient understands that

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent Signed by: X _____ _____

Signature Date

_____ _____

Print Name - Patient or Guardian Relationship to Patient

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Financial Policy Statement

The physicians at Forest Urgent Care committed to providing the highest level of medical care to our patients. To ensure that our patients fully understand our billing process, we ask you that you read and sign this financial policy statement.

The self pay rate doesn't apply to any patients with insurance. Forest Urgent Care will bill the medical insurance based on our contract agreement with the insurance companies. Patient is responsible for all co-insurance and deductible based on their medical insurance contract._____

COVID-19 RAPID TEST LIABILITY:

I understand and acknowledge the following: I acknowledge that If I request the CareStart COVID-19 rapid test I am electing to personally pay out of pocket for the Rapid Test. I have instructed this office not to bill my insurance carrier, if any, for these services. I acknowledge that I will be individually responsible to pay a fee in the amount of $50for the Rapid Test. I have been informed of the alternative testing options available and understand that these alternatives would likely qualify for coverage under most health insurance plans and may require no out-of-pocket expense; nevertheless, I desire and am electing to obtain the Rapid Test.

INSURANCE PARTICIPATION:

Forest Urgent Care Center participate with most major insurance company plans, and as a courtesy we will submit your claim to them. Although Forest Urgent Care Center participates with most major insurance plans, it is the patient's responsibility to ensure that their insurance company is listed below. If your claim remains unpaid by your insurance company for an extended period of time, we may ask for your assistance in obtaining payment from them. The following are a few of the major insurance companies, which Forest Urgent Care Center participate with:

AETNA 1199 CIGNA BCBS Wellcare EMBLEM GREAT WEST OXFORD TRICARE HIP EMPIRE PLAN MEDICARE AARP UNITED HEALTH CARE GEHA FIDELIS CARE METROPLUS GHI MAGNACARE AFFINITY

Note: We are not participating with Medicaid. Patient will be responsible for all Medical bills_____

PATIENT RESPONSIBILITY:

Without exception, it is the responsibility of the patient to pay their co-payment and any unpaid portion of the deductible at the time of service. Any additional co-payments and /or co-insurance will be billed to the patient directly as indicate by your insurance carrier. Your insurance company will mail you an explanation of benefits (EOB), which outlines the services rendered by Forest Urgent Care Center.

DENIED CLAIMS:

Forest Urgent Care Center will not become involved in disputes between you and your insurance company regarding uncovered charges, coordination of benefit issues, eligibility issues, pre-existing conditions or any matter, which causes the claim to be denied. Should your claim be denied for any of these reasons or any other reasons not listed here, the claim will become the responsibility of the patient and payment will be expected immediately.

LABORATORY CHARGES:

Please note that the services provided to you here at Forest Urgent Care Center may require outside lab work. Forest Urgent Care Center will forward your laboratory tests to a participating lab company whenever possible. You must contact the Lab Company directly should you receive any bills from them. Especially I-693 patient's, laboratory is not cover on office visit._____

PAYMENT OPTIONS:

For your convenience Forest Urgent Care Center offers a variety of payment options. We accept Visa, Master Card, American Express, Discover and cash. For patients who have out of state health insurances and want to submit the claim for reimbursement from their insurance company, our service charge is $150 (which excludes x-rays, vaccinations, blood work, EKG, suturing, IV, abscess drainage)

This Consent Signed by:

X_____ _____

Signature Date

_____ _____

Print Name-Patient or Guardian Relationship to Patient

FOREST
URGENT CARE

10-11 49th AVE Long Island City NY 11101 (347) 318-5488 Fax: (718) 729-3161

MEDICAL RELEASE FORM

I, _____ , hereby authorize and give consent to Forest Urgent Care Center to release the medical information regarding:

Name of patient: _____ DOB: _____

Address _____ Phone Number: _____

To be release only to the following Physician, Agency, or Organization:

If results are to be sent to patient only, please write "SELF"

NAME: _____

ADDRESS: _____

_____

X EMAIL ADDRESS: _____

FAX NUMBER: _____

The information should be limited to the following:

( ) COVID-19 test results only

( ) Complete Medical Record

( ) Including ( ) Excluding ( ) Not applicable
Any confidential HIV-related information.

( ) Specific items: _____

X Signature of authorizing person: _____

Relationship to patient: _____ Date: _____

Signature of Witness: _____ Date: _____