**Urgent Care of the Smokies**

**Patient Registration Form**

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Please present your insurance card and a photo ID at time of check-in.

Settlement of patient financial responsibility is expected at the time of service.

**TYPE OF** Insurance (present card at check-in) Self-Pay (payment due at the time of service)

 **VISIT** (Worker’s Comp) Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Please STOP now and notify the receptionist immediately if you are experiencing any of the following:**  **SEVERE chest pains SEVERE shortness of breath**  **Uncontrolled bleeding Allergic Reaction** **Any other life-threatening condition**  |
| **Patient Information:** *Please complete with the Patient’s Full Legal Name*  |
| **Last:**  | **First:**  | **Middle:**  |
| **Social Security Number:**  | **Date of Birth:**  | **Sex:** **\_\_\_\_\_\_\_\_\_ Male \_\_\_\_\_\_\_\_\_ Female**  | **Email address:**  | **May we send informational emails to you?** **\_\_\_\_\_\_ yes \_\_\_\_\_\_ no**  |
| **Home Phone: \_\_\_\_ Preferred**  | **Cell Phone: \_\_\_\_ Preferred**  | **Work Phone: \_\_\_\_ Preferred**  |
| **Street Address:**  | **City, State & Zip:**  | **Ethnicity/Race** *(Optional)***:**  | **Preferred Language** *(Optional)***:**  |
| **May we leave a message regarding your care (x-ray, lab results, etc.) on your preferred phone?**  **\_\_\_\_\_\_ yes \_\_\_\_\_\_ no**  | **Employer and Address:**  | **Occupation:**  |
| **Which pharmacy would you prefer to have your prescriptions sent to:**  |  **Relationship Status: S M D W Unknown** |
| **Emergency Contact:**  |
| **Name:**  | **Phone:**  | **Relationship to Patient:**  |
| **Guarantor Information:** *Please complete with the Guarantor’s Full Legal Name –* ***Guarantor is responsible party for the minor***  |
| **First:**  | **Middle:**  | **Last:**  |
| **Relationship to Patient:**  | **Date of Birth:**  | **Social Security Number:**  | **Sex:** **\_\_\_\_\_ Male \_\_\_\_\_Female**  |
| **Home Phone: \_\_\_\_ Preferred**  | **Cell Phone: \_\_\_\_ Preferred**  | **Work Phone: \_\_\_\_ Preferred**  |
| **Street Address:**  | **City, State & Zip:**  |
| **Employer Name:**  | **Employer Address:**  | **Employer Phone:**  |
| **PLEASE STATE THE REASON FOR TODAY’S VISIT:**  | **Is your visit today related to a motor vehicle accident?**  **\_\_\_\_\_\_ yes \_\_\_\_\_\_ no**  |

 **Urgent Care of the Smokies**

**PATIENT REGISTRATION FORM**

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| **Primary Policyholder Information:**  |  |
| **Insurance Name:**  |  |
| **Last:**  | **First:**  | **Middle:**  |
| **Date of Birth:**  | **Social Security Number:**  | **Sex:** **\_\_\_\_\_\_\_\_\_ Male \_\_\_\_\_\_\_\_\_ Female**  |
| **Street Address: (if different from patient)**  | **City, State, Zip:**  | **Relationship to Patient:**  |
| **Home Phone: \_\_\_\_ Preferred**  | **Cell Phone: \_\_\_\_ Preferred**  | **Work Phone: \_\_\_\_ Preferred**  |
| **Employer:**  | **Occupation:**  | **Other Emergency Contact:**  |
| **Secondary Insurance Information:** *Please complete this section for secondary insurance or if the insurance card is NOT present!*  |
| **Insurance Name:**  |
| **Policyholder Name:** (who carries the insurance)  | **Policyholder Date of Birth:**  | **Policyholder Social Security Number:**  |
| **Employer:**  | **Occupation:**  | **Copayment:**  |
| **How did you hear about us?**  | Dr. referral  | existing patient  |  friend/relative internet  | phonebook  |
|  signage TV hotel  | cabin rental/resort  | radio ad  | work pharmacy  |  |
| **Authorization, Acknowledgment and Release for ALL Treatment at this Facility *(please initial)***  |
| **Authorization For Treatment:** I voluntarily consent to the administration and cost of medical and surgical procedures, x-ray, and medication for myself and my dependents. **INITIAL \_\_\_\_\_\_\_\_** **Assignment of Insurance Benefits:** I authorize payment directly to Urgent Care of the Smokies for all benefits and the release of medical information for all services and payments otherwise payable to me. **INITIAL \_\_\_\_\_\_\_\_** **Guarantee of Payment:** I understand that I am financially responsible and agree to pay all of the charges that are not paid or billed to insurance or any other third party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance copays today or remaining balances following insurance payment upon receipt of balance statement. If you are unable to verify my insurance at the time of service, I will pay in full for all services. A $25 fee will be applied to your account if it has been placed with a collection agency for non-payment and/or your payment has been returned by the bank for any reason. **INITIAL \_\_\_\_\_\_\_\_** **Release of Records:** I authorize Urgent Care of the Smokies to release (verbal or in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or other health care operations, which may be liable to me or my practitioner(s) for charges for this treatment and for quality management, utilization review, transfer, and follow-up purposes. **INITIAL \_\_\_\_\_\_\_\_** **Receipt of Privacy Practices:** I acknowledge that I have received & read the Urgent Care of the Smokies Notice of Privacy Practices. **INITIAL \_\_\_\_\_\_\_\_** **I understand that a copy of this agreement may be used with the same effectiveness as the original. INITIAL \_\_\_\_\_\_\_\_**  |

**Patient / Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Urgent Care of the Smokies**

**PATIENT REGISTRATION FORM**

ACKNOWLEDGEMENT FORM

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| --- | --- | --- | --- |
| **Patient Information:** *Please PRINT with the Patient’s Full Legal Name*  |  |  |  |
| **First:**  | **Middle:**  |  | **Last:**  |  |
| **Date of Birth:**  | **Social Security Number:**  | **Sex:** **\_\_\_\_\_\_\_\_\_ Male**  | **\_\_\_\_\_\_\_\_\_ Female**  | **Ethnicity/Race** *(Optional)***:**  | **Preferred Language** *(Optional)***:**  |
| **Please read the below carefully**  |
| When you visit Urgent Care of the Smokies, it is very important that you feel safe telling your physician personal information that may be required to fully diagnose or treat you. Urgent Care of the Smokies has strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. The Health Insurance Portability and Accountability Act (“HIPAA”) rules require that Urgent Care of the Smokies Health provide all of our patients with the attached Notice of Privacy Practices on their first visit. The Notice describes how the medical information we receive from you may be used or disclosed by Urgent Care of the Smokies and your rights related to your access. **Receipt of Privacy Practices:** I acknowledge that I have received and read the Urgent Care of the Smokies Health Notice of Privacy Practices. **I understand that a copy of this agreement may be used with the same effectiveness as the original.**  |

**Patient / Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- |
| **Please tell us how to contact you to discuss your medical care**  |
| It is our policy to not release a patient’s confidential and/or unauthorized information by telephone or voicemail except for appointment confirmation. Whenever returning phone calls, we do not leave a message in voicemail if the name or telephone number is not on the recorded message to identify it. Information will not be left with an unauthorized person who may answer the telephone. **If there is a need for a follow-up call from Urgent Care of the Smokies, LLC, I authorize the staff of Urgent Care of the Smokies, LLC to leave medical information pertaining to my care by the following methods and will assume responsibility to notify Urgent Care of the Smokies, LLC , in writing, if this information changes.**  |
| Call Home Phone:  yes no  | Call Cell Phone:  yes no  | Can Call Pager:  yes no  | Can Call Work Phone: yes no  | Can leave a message on voicemail and/or answering machines: yes no  |
| **Please specify the names of the people with whom we can discuss your medical care:** |
| Spouse Name:  | Parent Name:  | Other Names including the Relationship:  |

**Receipt of Privacy Practices:** I acknowledge that I have received and read the Urgent Care of the Smokies Notice of Privacy Practices. **I understand that a copy of this agreement may be used with the same effectiveness as the original.**

**Patient / Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**