

PATIENT INFORMATION

Please present your insurance card and photo ID at check-in

Patient's Name: Last _____ First _____ Sex: M / F

Date of Birth: (mm/dd/yy) _____ Preferred Pronoun: _____

Address: _____ Apt _____ City _____ State _____ Zip Code _____

Mobile #: _____ Home #: _____

Email: _____ Occupation: _____ Race: _____

Emergency/Alternate: Name _____ Phone _____ Relationship _____
Contact _____

Pharmacy Name: _____ Pharmacy Phone #: _____

Pharmacy Address: _____

Primary Care Provider: _____ Primary Care Phone #: _____

Primary Care Address: _____

REGARDING YOUR VISIT TODAY

Please list any concern(s) that prompted your visit: _____

Please list any medical conditions/history: _____

Please list any medications you are allergic to: _____

Please list any medications you take long-term: _____

Please list any surgical history: _____

Please list any family medical history: _____

HOW YOU HEARD ABOUT US

We would **greatly** appreciate you letting us know how you heard about our clinic and/or if you were referred here by anyone! Your feedback helps us immensely in maintaining operations ☺ Thank you!

Passing by / We're neighbors! **Google / Yelp** **Friends / Family** **Other:** _____

PATIENT AGREEMENT

CONSENT TO TREATMENT

I hereby request and consent to diagnostic, therapeutic, and medical treatment by UMD Urgent Care (hereafter referred to as the practice) as determined necessary by the professional medical judgment of the on-call provider at the time of service. This includes, but is not limited to, X-Rays, blood tests, diagnostic tests, the obtainment of e-script histories, and the administration of medications and vaccinations (as applicable). I am aware that medicine and its related procedures is not an exact science, and I acknowledge that no guarantees have been made to me as to the outcome of any procedures, treatments, or examinations. I permit the practice to take X-Rays, photos, and other images of me during the course of my care, which may be used for reasons such as the documentation of my medical status and for my overall medical benefit.

For Female Patients: I understand that X-Rays may injure a fetus, and it is my responsibility to notify the practice if I am or may be currently pregnant.

Print Patient Name

Signature of Patient or Legal Guardian

Date

PRIVACY AGREEMENT

I agree that the practice may use and disclose my protected health information (PHI) to carry out treatment, payments, and healthcare operations (TPO), and for any other reasons that are permitted or required by law. I have the right to request copies of my medical records and X-Rays, which can be provided in paper and CD format, respectively, and the practice may charge a reasonable cost-based fee. I understand my rights and restrictions as outlined in this policy, and I am aware that the practice reserves the right to revise its privacy policy at any time. I acknowledge my right to review a copy of the practice's privacy policy prior to signing this form, and my right to obtain a copy of said policy.

Print Patient Name

Signature of Patient or Legal Guardian

Date

PAYMENT AGREEMENT

Out-of-Pocket Patients:

At the time of service, if I do not have insurance coverage, have an insurance plan that is not accepted by the practice, or have an insurance plan that the practice is unable to verify at the time, I agree that full payment is to be made at the time of service. The practice reserves the right to modify its prices at any time, and I understand that these charges are non-negotiable, and that I have a right to deny services. If I am unable to make financial decisions at the time of service, I agree that the practice's staff may administer services deemed necessary for my health.

Insured Patients:

I hereby authorize the practice to submit claims to my active insurance (on the date of service) on my behalf, and I instruct my insurance company to make payments directly to UMD Urgent Care. This is a direct assignment of benefits under this policy. A photograph of this assignment shall be considered as effective and as valid as the original, and I authorize the practice to initiate a complaint to the insurance commissioner for any reason on my behalf.

I acknowledge that it is my responsibility as the insured to be aware of the current terms of my insurance plan, and that I am responsible for notifying the practice of any coverage changes at the time of service. **I agree that I must pay the co-payment at the time of service, and I understand that the eligibility and co-payment amount determined at the time of service are not guaranteed.** By signing below, I permit the practice to bill me for any additional co-payments, co-insurances, and deductibles that may exist, as they are determined by my insurance company and plan. I understand that I may be responsible for the full balance of services, should my insurance plan be inactive or not cover my treatment for any reason.

I am aware that a 5% late fee will be applied to any overdue balances, and that nonpayment past three (3) months from the due date may result in my account being referred to a collection agency.

Print Patient Name

Signature of Patient or Legal Guardian

Date