Patient Registration

Patient Last Name _____ Middle Initial _____ Patient First Name _____

Race (circle): American Indian Alaska Native Black or African American Asian White

Native Hawaiian/Other Pacific Islander Other _____

Preferred Language _____ Ethnicity (circle): Hispanic or Latino Not Hispanic or Latino

E-mail _____ Gender M____ F_____ Employer (if applicable) _____

Social Security Number _____ Date of Birth _____

Mailing Address _____

City _____State _____ Zip _____

Home Phone _____ Cell Phone _____

Primary Care Physician _____ Pharmacy _____

Emergency Contact Name _____ Emergency Contact # _____ Relation: _____

Insurance ☐ Self Pay ☐

What are we seeing you for? _____

•••••••••••••••••••• **Primary policyholder, guarantor and patients under 18**••••••••••••••••••••

Policyholder/Guarantor Name _____

Policyholder/Guarantor Contact # _____ Address _____

City _____ State _____ Zip _____

Policyholder/Guarantor SSN _____ Date of Birth _____

Relationship to Patient _____

•••••••••••••••••••••• **Secondary policyholder**••••••••••••••••••••••

Policyholder/Guarantor Name _____

Policyholder/Guarantor Contact # _____ Address _____

City _____ State _____ Zip _____

Policyholder/Guarantor SSN _____ Date of Birth _____

Relationship to Patient _____

Authorization For Care & Treatment I consent to the following treatment: administration and performance of all treatments, administration of any needed anesthetics, performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, use of prescribed medication, performance of diagnostic procedures, tests, and/or cultures, performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending provider. I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. I agree to provide accurate and thorough information regarding my medical history and any conditions or events that may impact medical decisions. This consent will remain in full force until revoked in writing.

HIPAA Acknowledgment I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, Obtain payment from third-party payers. Conduct normal healthcare operations such as quality assessments and physician certifications. I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Release of Information and referrals I, the undersigned, acknowledge and give permission to Grand Ave Urgent Care (GAUC) to disclose my healthcare information for the purposes of further treatment, payment, and healthcare operations. A photocopy of this consent shall be considered as valid as the original.

Insured Patients GAUC does participate with numerous insurance companies. Co-payments, co-insurances and/or non-covered services are required to be paid by you in full at the time of service. Insurance contracts state the balance and co-payments cannot be waived. Such insurance may include, but is limited to, private commercial insurance, auto insurance, workers compensation, Medicare and Tricare. There are some insurance carriers with which we do not have a contract. I will be responsible for the entirety of the cost of services and considered an uninsured patient. I certify that the information given regarding my insurance is accurate and current to the best of my knowledge. If a claim is denied by insurance because I did not provide the correct insurance information or respond to any information requests in a timely manner, I understand that I will be financially responsible for any and all treatment(s) received.

Uninsured Patients Payment is due at the time of service at the current self-pay rate. I will be responsible for services rendered at an uninsured discount for the visit, procedures and other medical services.

Disclosure of Ownership Interest GAUC is wholly owned by John Jacobs, N.P. Because the provider owns the practice, he is best able to ensure the highest level of care is provided.

Notice of Separate Billing: The provider may order laboratory and/or other radiology services for you while you are in our facility. We do not bill for any services sent out to another facility. If you have any questions pertaining to your third-party lab or radiology bill, please contact their billing office as we are not their billing department.

Collections I understand that if my account is not paid in full, my account will be turned over to a third-party collection company for further processing and I will be responsible for paying any collection fee incurred by the practice. Any such fees will be added to the outstanding balance owed. No additional appointments will be made for delinquent accounts until they are brought current.

Occ Med Patients Payment for services rendered at GAUC for Occupational Health Medicine will be the responsibility of the company for whom I am employed. I am responsible for any services provided but not covered by my employer.

I give permission for GAUC to discuss any health-related issues with the following individual(s):

Patient Name: _____

Relationship to Patient: Self Mother Father Grandparent Guardian Other_____

Patient / Guardian Signature: _____ **Date:** _____