

PREMIER URGENT CARE

REGISTRATION FORM

(Please Print)

Date:		Time:				
PATIENT INFORMATION						
Last Name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss	Marital Status:	
				<input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Single / Mar/ Div/ Widow/Separated	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name? (Former name):			Age:	Date of Birth:	Sex: M F
Street Address:			Social Security #:		Home Phone Number:	
City:	State:	Zip Code:	Other Phone Numbers:			
			Cell:	Work:		
Chose clinic because/Referred to clinic by (please check one box): <input type="checkbox"/> Dr. <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Other _____						
<input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to home/work <input type="checkbox"/> Yellow Pages						
Other family members seen here: _____				Primary Care Physician:		

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Date of Birth:	Address (if different than patient):		Home Phone Number:	
Is this person with the patient today? Yes No					
Occupation:	Employer:			Work Phone Number:	
Is this patient covered by insurance? Yes No					
Primary Insurance Company Name:					
Subscriber's Name (If not patient):	Subscriber's S.S. #:	Birth Date:	Group Number:	Policy Number:	Co-payment: \$
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					

Secondary insurance (if applicable):

Subscriber's Name (If not patient):	Subscriber's S.S. #:	Birth Date:	Group Number:	Policy Number:	Co-payment: \$
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					

EMERGENCY CONTACT INFORMATION

Name of Contact (not living at same address)	Relationship to patient		Phone number
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The above information is true to the best of my knowledge. I authorize Premier Urgent Care to apply for benefits on my behalf for covered services rendered by Premier Urgent Care; and I request my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Premier Urgent Care or the insurance company to release any information required to process my claim. I understand that my records and medical information may be shared with my employer when that employer has requested the services provided. I consent for treatment by the patient care staff at Premier and acknowledge that no guarantee can be made concerning the results of that treatment. I acknowledge that the Notice of Privacy Rights has been made available to me.

Patient (Guardian) Signature: _____

Date: _____

Premier Urgent Care Patient Financial Policies

Thank you for choosing Premier Urgent Care for your medical needs. We look forward to providing medical treatment.

Whenever possible we will file your charges with your insurance carrier on your behalf.

In most cases reimbursement is be received within 45 to 60 days although there are some exceptions.

However, it is ultimately the patient's responsibility to know and understand what services are covered under their individual insurance policy.

Patients without insurance coverage are required to pay the balance in full at the time of service.

We can not file claims to Workers Comp programs unless your employer has authorized your treatment.

We do not file claims for automobile-related accidents with auto insurance plans.

Common insurance claim denials include, but are not limited to:

- Pre-existing medical condition(s)
- Patient responsible for meeting policy deductible
- Insurance not in effect at the time of service
- Coverage by more than one plan in which coordination of benefits has not been arranged
- Policy maximum has been reached
- No referral for the service (if the policy requires you to list a primary care physician)
- Medical services rendered is not covered by the insurance policy

Insurance companies can deny claims for a variety of reasons. A few of the most common denial reasons are listed above. **Any unpaid balance remains the patient's responsibility.**

To assist in expediting your claim, you will be asked at every visit to verify your information and make any applicable changes. Please inform us of any demographic and insurance changes. If your insurance has changed or if you have two insurance carriers, please advise the front desk staff and provide them the insurance cards.

If any changes in your insurance information coverage is not provided and/or received within the insurance carrier timely filing period, the patient will become responsible for any balance of the account.

Co-pays are always due at the time of service. If you do not pay your copay, you will be charged a billing fee of \$10.

We accept the following payment types:

- Cash
- Check (returned check fee is \$25.00)

Debit and credit cards:

- Visa
- MasterCard
- Discover
- American Express

I have read and understand the above patient policies. I understand that this office will file an insurance claim on my behalf based on the information I provide.

I understand that I will be fully responsible for payment of any and all medical services denied by my insurance company as applicable by state and / or federal law.

Patient Signature

Date