Patient Registration Form

FASTMED URGENT CARE

Fields identified with an (*) must be completed.

Today's Date: _____

PATIENT INFORMATION

Patient Name (First, Middle, Last)*: _____ Date of Birth*: _____

SSN: _____ Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Mailing Address*: _____ Apt. #: _____

City*: _____ State*: _____ Zip Code*: _____

Contact Numbers: Main*: _____ Mobile: _____ Work: _____

☐ I give my permission to have messages concerning care left on voicemail.

Please provide your email address: _____ so we can send you receipts and healthcare information. Your email address will not be provided to a third party.

Emergency Contact*: _____ Emergency Contact Phone*: _____

PCP

Primary Care/Provider (PCP) Name: _____ Practice Name: _____

PCP Phone: _____

ETHNICITY/RACE

☐ African-American ☐ American Indian/Alaska Native ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Pacific Islander/Hawaiian

☐ Decline Response Preferred Language: _____

HOW DID YOU HEAR ABOUT FASTMED?

Check all that apply. ☐ Online ☐ Drive By ☐ Friend/Family ☐ Event ☐ Flyer ☐ Medical Provider ☐ Other Advertising

INSURANCE INFORMATION

Please provide appropriate insurance coverage information to ensure appropriate claims processing or identify your visit as self-pay if you are not currently covered by a health insurance plan.

Primary Insurance: _____ Secondary Insurance: _____ ☐ Self Pay

☐ **The patient is also the Insurance Subscriber. If checked, please continue to the Responsible Party section.**

If the Insurance Subscriber is not the patient, please complete the following:

Insurance Subscriber's Name (First, Middle, Last): _____ Relation: _____

Date of Birth: _____ SSN: _____ Employer: _____

RESPONSIBLE PARTY

☐ **Financially responsible individual is the same as the Insurance Subscriber identified above.**

Complete for minor patients or when patient is not financially responsible for the account.

Name of Person Responsible for this Account: _____ Relation: _____

Date of Birth: _____ SSN: _____ Phone: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

WORKERS' COMPENSATION ("WC") AUTHORIZATION

Employer Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

WC Carrier: _____ Phone: _____ Claim #: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Injury: _____ Injury Reported to Employer: ☐ Yes ☐ No

I clearly understand and agree that all services rendered to me will be charged directly to me in the event that workers' compensation benefits are denied.

Patient Signature: _____ Date: _____

For Office Use Only

Employer Contact Providing Authorization to Treat: _____

FastMed Employee Verifying Injury: _____

Drug Screen Required: ☐ Yes ☐ No

FINANCIAL POLICIES

At the time of service, FastMed collects from you the estimated amount of patient responsibility based on your specific insurance plan, our insurance contracts, and the eligibility information provided by your insurance company. Following your visit, you will receive an explanation of benefits from your insurance company stating the amount paid by your insurer and the remaining balance owed by you, if any. Patients are financially responsible for all services rendered that are not paid for by their insurance(s). All medical services are billed by FastMed and I authorize payment for insurance benefits, which may otherwise be payable to me, directly to FastMed. I authorize the release of information concerning my (or my dependent's) healthcare, advisement, and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I understand that I will be billed directly by and agree to pay FastMed for any outstanding balances should my credit/debit card be declined or canceled. I understand that a $10 late fee will be applied to any unpaid balance I owe that is not paid within 30 days. I understand that my account will enter collections after 60 days of non-payment. I agree to reimburse FastMed the actual fees of any collection agency, which may be based on a percentage at a maximum of 40% of the unpaid balance, and all costs and expenses, including reasonable attorneys' fees incurred in such collection efforts. If my account is sent to collections, such fees may be assessed by the collection agency on behalf of FastMed. I also understand that I may be responsible for my balance due to any chargeback, reversal, or dispute as a result of my credit card company's or bank's refusal to remit payment to FastMed.

Patient/Representative Printed Name: _____

PAYMENT AUTHORIZATION

As a courtesy to our patients, FastMed keeps a credit/debit card authorization on file for each patient visit and will charge the card for any balance not paid by your insurance for that visit only. FastMed will also refund the card on file automatically if there are any amounts owed to you for that visit. The credit/debit card used for the visit will be the credit card on file unless you request a different credit/debit card be kept on file. You will receive an email with the notice for any charge or refund if you have provided us your email address. If the visit has a $0 balance, then there will be no further charge or refund. If the visit is being billed under a government insurance plan, the credit card on file policy does not apply.

I authorize FastMed to charge my credit/debit card up to $200 for any outstanding patient responsibility balance that remains after insurance reimbursements have been applied for authorized medical services received at FastMed. I also authorize FastMed to issue a refund to the same credit/debit card if there is a balance due to me.

Cardholder/Representative Authorizing Signature: _____ Date: _____

Cardholder/Representative Printed Name: _____ Email Address for Notice: _____

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES*

I have read and had questions addressed concerning FastMed Urgent Care's Notice of Privacy Practices.

Patient/Patient Representative Signature:_____ Date: _____

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A good faith effort was made in attempting to obtain written acknowledgment of receipt of the FastMed Urgent Care Notice of Privacy Practices. Acknowledgment could not be secured for the following reason(s):

☐ Patient/representative refused to sign. Date of refusal: _____

☐ Communication barriers prohibited us from obtaining an acknowledgment

☐ An emergency situation prevented us from obtaining an acknowledgment

☐ Other. Please explain: _____

Staff Signature: _____ Date: _____

ACKNOWLEDGMENT OF PATIENT CHOICE AND PATIENT RIGHTS AND RESPONSIBILITIES POLICY*

In connection with your treatment at FastMed Urgent Care, your FastMed Urgent Care healthcare provider may recommend certain ancillary services as part of your overall care. FastMed Urgent Care offers certain ancillary services that patients may require such as X-rays, limited lab services, and certain pharmaceuticals. FastMed has arranged for limited durable equipment (DME) to be available on site for patient convenience through a third-party vendor. While FastMed Urgent Care makes these services available, we want you to know that if your FastMed Urgent Care healthcare provider prescribes any of these services for you, you are free to choose any provider or supplier you wish and are not required to obtain these services through or at FastMed Urgent Care. FastMed Urgent Care will offer local providers of such items and services to you upon your request.

I have been given the opportunity to review the forgoing regarding FastMed Urgent Care's Patient Choice Policy and have had any questions answered about the same addressed. By signing below, I acknowledge my understanding of this policy and my rights thereunder.

I have been provided FastMed's Patient Rights and Responsibilities Policy for review. I have had any necessary questions answered.

Patient/Patient Representative Signature: _____ Date: _____

CONSENT FOR MEDICAL TREATMENT*

I, the patient or authorized patient representative, consent to any medical examination, evaluation, and treatment regarding any illness, injury, and/or health concern affecting me at any time I present to FastMed Urgent Care for medical treatment. These services may include, but are not limited to, laboratory procedures, X-ray examinations, and medical and/or surgical treatment procedures.

Patient/Patient Representative Signature: _____ Date: _____

FOR MINOR PATIENTS

I, the undersigned, attest that I am the custodial parent or legal guardian of the above-referenced minor and hereby authorize FastMed Urgent Care to administer treatment, as it so deems necessary, to the minor. In the event that the minor has received treatment at the practice before the date of this consent form, I authorize such treatment in addition to the treatment mentioned above. In no event shall my signature to any such document have any effect on this consent form.

Name of Custodial/Legal Guardian: _____ Relationship to Minor: _____

Other Individual Authorized to Consent for Treatment for Minor Child*_____ Date of Birth: _____

Custodial/Legal Guardian Signature: _____ Date: _____

*Consent to allow named individual to consent for minor treatment will remain in effect until written notice is provided revoking consent. Version May 2017