PLEASE PRINT CLEARLY

MRN:

[illegible] DEMOGRAPHICS

PERSONAL INFO

SSN: ______-______-________ Gender: ☐ Male / ☐ Female DOB: ______/______/________

First Name: ____________________ MI: ____ Last Name: ____________________ (Jr / Sr / III / IV)

Mailing Address: ____ Apt #: __________

City: ______________________ State: ______________ Zip: __________

Phone #: _____-_____-______ Work #: _____-_____-______ Alt/Cell #: _____-_____-______

E-MAIL Address: ____________________ Pharmacy: ____________________

Employer: ______________________________
Company Name

____
Address City, State Zip

Marital Status: ☐ Single / ☐ Married / ☐ Divorced / ☐ Widowed

Employment Status: ☐ Not Employed / ☐ Full Time / ☐ Part Time / ☐ Retired

Student Status: ☐ Not a Student / ☐ Full Time / ☐ Part Time

Race/Ethnicity: ☐ African American / ☐ Asian / ☐ Caucasian / ☐ Hispanic / ☐ Native American / ☐ Other

PRIMARY CARE PHYSICIAN

If Urgent MD is not your primary care provider, please complete:

Physician Name: ______________________

Address: ______________________

Phone #: __________ Fax #: __________

Preferred Pharmacy:

Pharmacy: ______________________

Address: ______________________

Phone #: ______________________

INSURANCE INFO

PRIMARY Insurance Company: ______________________________

Policy Holder's Name: ______________________________

Relationship to Patient: ______________________________

Policy Holder's DOB: ______/______/________ & SSN: ______-______-________

Policy Holder's Employer: ____
Company Name Address City, State Zip

SECONDARY Insurance Company: ______________________________

Policy Holder's Name: ______________________________

Relationship to Patient: ______________________________

Policy Holder's DOB: ______/______/________ & SSN: ______-______-________

Policy Holder's Employer: ____
Company Name Address City, State Zip

TURN PAGE OVER

Patient Rights and Responsibilities

MRN:

ALL PATIENTS

Identification and Insurance
All insurance cards and a valid photo ID must be presented to the front desk at the time of arrival. When changes occur in my insurance coverage, it is my responsibility to notify the front desk personnel.

Collection/Payment Policy
***Patients without insurance/Self Pay: I understand that I will be required to pay all charges at the time of service.**

***Patients with insurance: I understand that I will be required to pay all co-pays, deductibles, coinsurance and non-covered services at the time services are rendered. If I have two or more active insurance policies, I may be required to pay the co-pay of either my primary or secondary insurance (lesser of the two) at the time of service. Urgent MD Healthcare Services, P.C. is contracted as a Primary Care Physician's Office, NOT as an Urgent Care. We file with a PCP co-pay and fee schedule and do not file any charges as an Urgent Care Facility.**

We accept cash, checks, Visa, MasterCard, Discover and American Express. We process all checks as EFT's (Electronic Funds Transfer). If your check cannot be processed at the time of service, you will be required to pay by cash or credit card. Returned checks are subject to a $30.00 Returned Check Fee and a $10.00 Bank Fee.

Acknowledgement of Receipt of Notice of Privacy Practices
I have received a copy of the Notice of Privacy Practices for Urgent MD Healthcare Services, P.C.
****The Notice of Privacy Practices brochures are located at the front desk.****
I hereby acknowledge that Urgent MD Healthcare Services, P.C. will share my medical information, as permitted under federal law (H.I.P.A.A.) and Georgia state law, with my healthcare providers through a health information exchange.

Authorization for Medical and/or Surgical Treatment
I authorize Urgent MD Healthcare Services, P.C. physicians and whomever they may designate as his/her assistant(s) to administer necessary treatment. I also certify that no guarantees or assurances have been made as to the results that may be obtained from any treatment.

E-Medication History Consent: Urgent MD has transitioned to electronic medical records in order to provide you with greater treatment. We now have the ability to send and retrieve your medications electronically. Please sign below for permission to download your electronic medication history.

Urgent MD Healthcare Services, P.C. is strictly limited to outpatient services. If hospital admission is required, patients will be referred to the appropriate specialist in whom the physicians of Urgent MD Healthcare Services, P.C. have the most trust or the one(s) designated by your insurance carrier. If you have an emergency after hours you should go to the emergency department of your choice or the one designated by the carrier of your insurance.

INSURED PATIENTS ONLY

Assignment of Insurance Benefits
I authorize Urgent MD Healthcare Services, P.C. dba Urgent MD, LLC to furnish all information related to my diagnosis and treatment to my insurance carrier(s) and their authorized agent(s).

I hereby assign all payments for medical services rendered to my dependents or myself to Urgent MD Healthcare Services, P.C. dba Urgent MD, LLC. *I understand that I am responsible for any amount not covered by my insurance carrier.*

Insurance Filing Policy / Responsible Party
I understand that Urgent MD Healthcare Services, P.C. will file my insurance claim as a courtesy. However, if a response is not received within 30 days, I may need to contact my insurance company regarding the claim.
I understand that co-payments are always required to be made in full at the time of service. Urgent MD Healthcare Services, P.C. will also file laboratory work with my insurance company. If my insurance company requires lab services to be billed from a specific lab, it is my responsibility to inform my doctor so that I may be given an order to take to the lab of my choice.

There are many lab tests that we are capable of performing in our office; therefore, we are able to bill your carrier for these charges. If there is a test that we are unable to perform in our office, we will refer you to a lab that is able to bill your carrier directly for these services.

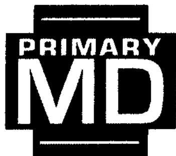
I understand that my insurance policy is a contract between my insurance company and me. I agree to be responsible for any services charged by Urgent MD Healthcare Services, P.C.

MINORS: All services rendered to minor patients will be the financial responsibility of the legal guardian.

SIGN

Confirmation of Information
This is to certify that the information I have provided is true and accurate and that I understand and agree to all the patient responsibilities outlined in the above.

Signature: ______________________________ **Date:** ____________



MRN:

PHI Internal Release Authorization

This authorization form permits: **Urgent MD Healthcare Services, PC**

To use or disclose Protected Health Information described in the section below to the entity or person listed for the following patient:

Patient Name: ______________________ DOB: __________ Phone #: ______________

Address: ______________________________ City/State/Zip: ______________________

Method(s) to release to you: Please fill out boxes for those methods you wish to receive your PHI and check boxes for authorized information.	**Person authorized to receive information on your behalf:** Please list the person's name, relationship to you and check information they are able to receive.
Voicemail Phone number: ______________________ ☐ Appointment Information ☐ Lab/test results **Fax:** ______________________ ☐ Appointment Information ☐ Financial Information ☐ Medical Information (please list) ______________________ Other ______________________	**Emergency Contact** Name: ______________________ Relationship: ______________________ Phone number: ______________________ ☐ Appointment Information ☐ Financial Information ☐ Medical Information (please list) ______________________ Other ______________________ *You may request another form for additional person(s).

The purpose of this authorization is to meet the patient's request for information disclosures and uses. This practice will verify the identity of any entity or person requesting Protected Health Information by verifying voicemail number, email address or name of authorized person(s).

This authorization shall remain in force until revoked by the patient in writing.

Patient Rights: I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

______________________________________ ______________

Signature of Patient or Personal Representative Date

____

Description of Personal Representative's Authority (attach necessary documentation)