Urgent Care *of* Mountain View

Registration Form

REASON FOR VISIT

☐ Injury ☐ Illness ☐ Workers Comp ☐ Auto Accident
☐ Drug Screen ☐ Physical

☐ Other: _____

Welcome to Urgent Care of Mountain View. Please take a moment to complete this Registration Form. Please present your insurance card at the time of check-in. Payment of the patient's financial responsibility is expected at time of service.

PATIENT INFORMATION

Patient Name:

Last: _____ First: _____ Middle Initial: ____

Date of Birth: _____/_____/_____ Social Security Number: _____

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Address: _____

City: _____ State: _____ Zip Code: _____

Contact Information: *Preferred contact method is* ☐ *Cell Phone* ☐ *Home Phone* ☐ *Work Phone* ☐ *Email*

Cell Phone: (_____)_____ -_____ Home Phone: (_____)_____ -_____

Work Phone: (_____)_____ -_____ Email: _____

I consent to receiving phone calls, voicemails, and other phone communications regarding my care: ☐ Y ☐ N

. . . . . .

EMERGENCY CONTACT

Contact Name: Last: _____ First: _____

Phone: (_____)_____ -_____ Relationship: _____

I consent to receiving messages regarding my care on my Emergency Contact's preferred phone: ☐ Y ☐ N

. . . . . .

IS THIS AN ON-THE-JOB OR OTHER WORK-RELATED INJURY?

Is this an on-the-job or other work-related injury? ☐ Y (If Yes, **STOP.** Please complete below) ☐ N

Date of Injury: _____/_____/_____ Time of Injury: _____ ☐ AM ☐ PM

Employer Name: _____ Employer Phone: (_____)_____- _____

Supervisor Name: _____ Title: _____

Address: _____

City: _____ State: _____ Zip Code: _____

. . . . . .

PARENT AND/OR GUARANTOR'S NAME:

Last: _____ First: _____ Middle Initial: _____

Date of Birth: _____/_____/_____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____

Employer: _____

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INSURANCE INFORMATION:

Primary:

Carrier: _____ Subscriber ID: _____ Group Number: _____

Policy Holder Name: _____ Date of Birth: ____/____/____

Secondary: Please notify staff if secondary insurance should be billed. I have Secondary Insurance ☐ Y ☐ N

Carrier: _____ Subscriber ID: _____ Group Number: _____

Policy Holder Name: _____ Date of Birth: ____/____/____

I understand and consent to receiving billing information via text message ☐ Y ☐ N

Primary Care Physician:

Contact Name: Last: _____ First: _____

Authorization and Release Authorization For Treatment: I voluntarily consent to the administration and cost of medical and surgical procedures, x-ray, and medication for myself and my dependents.

Authorization to Receive Emails, Text Messages, Faxes, and Phone Communications: I voluntarily consent to receive communications regarding my appointments, lab results, payment information and more.

Assignment of Insurance Benefits: I authorize payment directly to this urgent care center for all benefits otherwise payable to me.

Guarantee of Payment: I understand that I am financially responsible and agree to pay all the charges that are not paid or billed to insurance or any other third-party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance copays, coinsurances, and deductibles today. If you are unable to verify my insurance at the time of service, I will pay in full for all services. If self-pay, I understand that there may be additional charges for services and treatment above the basic pay rate.

Release of Records: I authorize this urgent care center to release (verbal or in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or other health care operations which may be liable to me or my practitioner(s) for charges for this treatment and for quality management, utilization review, transfer, and follow-up purposes.

Receipt of Privacy Practices: I acknowledge that I have received and read the Notice of Privacy Practices of this urgent care center.

IMPORTANT: I understand that a copy of this agreement may be used with the same effectiveness as the original. If the patient is not 18 years of age or older, a parent or legal guardian must sign.

PATIENT SIGNATURE: _____ _____

Signature *(must be 18 years old to sign)* Date

RESPONSIBLE PARTY: _____ _____ _____

Signature Relationship Date