



Patient Registration Form

Personal Information

Last Name		First Name	
Middle Name	Social Security Number		DOB
Marital Status	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	
Race <input type="checkbox"/> White <input type="checkbox"/> Black/African America <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaskan Native	Employer		
Phone <input type="checkbox"/> Home <input type="checkbox"/> Cell	E-mail		
Mailing Address			Apt #
City	State	Zip	
If we need to call your home for any reason and cannot reach you, may we leave a message on your voice mail or with a responsible adult? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>By checking "no," I acknowledge that I, the patient/guardian, am fully responsible for contacting MedAccess Urgent Care, PLLC for test results.</i>			Please initial below if it is OK for MedAccess Urgent Care, PLLC to contact you by e-mail. 
Signature: _____			

Medical Information

Symptoms <i>(required)</i>	Primary Care Physician	
Emergency Contact	Phone Number	Relationship

Insurance Information (for policy holder)


Last Name	First Name	
Social Security Number	DOB	
Phone	Relationship	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address		
City	State	Zip

Guarantor (responsible party)

Last Name	First Name	
Social Security Number	DOB	
Phone	Relationship	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address		
City	State	Zip

Marketing Information

How did you hear about us? Billboard Newspaper Radio Internet Referral Mailer TV Other:
 Clinic Phone Book Work Doctor Friend Relative Existing Patient _____

MedAccess Urgent Care, PLLC sends occasional e-mails to its clients including updates on new treatments, seasonal reminders, public services announcements and community events. We are committed to customer service, and we will not clutter your inbox. If you wish to opt-out of these updates, please initial here: 

Treatment Consent

CONSENT FOR MEDICAL TREATMENT

I voluntarily present for treatment and consent to my physician and whomever they may designate as their assistant, associate, treating physician, and patient care staff to provide my care. Such care may include, but not limited to, diagnostic procedures. Physiotherapeutic treatment, other treatments and medications, pathologic and radiological evaluations and procedures and considered advisable in my diagnosis, treatment, and course of care. I acknowledge that no guarantee can be made or has been made as to the results of treatments or examinations at MedAccess Urgent Care, PLLC (MAUC).

RELEASE AND USE OF PATIENT INFORMATION

I authorize the release of my medical records, information, treatment and advice, and specific health information to:

1. AN EMPLOYER who requests services (including history, physical, laboratory and diagnostic tests, and screening for the presence of drugs, alcohol, or marijuana)
2. INSURANCE COMPANY or other third party payer and their agents as well as any review organization or government agency for the purpose of determining eligibility, available benefits and obtaining payment for services provided.
3. EDUCATIONAL OR SCIENTIFIC INSTITUTIONS authorized health care professionals in training, internal quality improvement, risk management and legal counsel when it is judged that my ongoing medical care, medical research, quality improvement, healthcare education or science will benefit; for any purpose authorized by law.
4. TREATING PHYSICIANS on staff at MAUC; to another health care facility upon direct transfer and to my attending consulting, referring and/or primary care physicians for follow up care. I understand that if I refuse to authorize access to my records for coordination of care, my treatment could be adversely affected.

I understand this information concerning medical care, advice or treatment may include history and physical/diagnosis/laboratory and diagnostic testing/specific information concerning alcohol abuse/mental health/drug abuse/human immune-deficiency virus/hepatitis/ or other infectious diseases. I understand that I have the right to revoke this authorization. If my revocation prevents payment or reduces payment for services received, I become responsible for payment.

ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT GUARANTEE

In consideration of services provided by MAUC, I hereby assign and transfer to MAUC any and all rights, which I have against insurance companies, government agencies, or third party payers, for payment of charges for services provided by MAUC to me or to one of my dependents. I understand that I am responsible for and will pay the portion of my bill not covered by insurance companies, government agencies, or third party payers. In consideration of services to be provided, I agree to pay MAUC in accordance with the regular rates and terms of MAUC. I further agree to pay the account in full upon receipt of my billing statement unless payment arrangements are made with MAUC. I authorize said payments to be applied to any unpaid MAUC balance for which I am responsible.

I give consent, authorize release, and assign benefits to MAUC: _____
Patient/Guarantor Signature

SIGN HERE

RECEIPT OF HIPAA PRIVACY NOTICE

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how MAUC may use and disclose my protected health information. I understand that MAUC reserves the right to change the privacy notice and that a copy of the revised notice will be available to me.

SIGN HERE

Patient/Guarantor Signature

