PATIENT REGISTRATION

Date of Exam:_____

EXPRESS DOCS WALK-IN URGENT CARE CENTER

First Name: _____ **Last Name:** _____

Date of Birth: _____/_____/_____ **Sex:** ☐ M ☐ F **Status:** Married/Single/Divorced/Widowed

Address: _____

City_____ **State**_____ **Zip Code**_____

Home Phone: (_____) _____ **Cell Phone:** (_____) _____

Social Security #: _____-_____-_____ **E-Mail Address:** _____

Primary Care Physician: _____ **Phone Number:**_____

Reason For Visit:_____

_____

How Did You Hear About Us?_____

Do you give permission for ExpressDocs to leave a message on your voicemail with test results?
(please check): ( ) Yes ( ) No

Do you give permission for ExpressDocs to send E-Mails to the E-Mail address you listed above?
(please check): ( ) Yes ( ) No

IF DIFFERENT FROM ABOVE: Person responsible for bill/parent (PRINT name of Mother & Father if child is < 18)

Guarantor Name(s): _____
Date of Birth: _____/_____/_____SSN:_____
Contact Number: (_____) _____-_____ Alternative Number: (_____) _____-_____
Relationship to Patient: (please check): ( ) Spouse ( ) Parent ( ) Other: _____
Address: _____
City_____State_____Zip Code_____

Emergency Contact:

Name: _____Relationship:_____
Address: _____
Contact Number: (_____) _____-_____Work Phone: (_____) _____-_____

Primary Insurance:

Plan Name:_____ID#:_____

Secondary Insurance:
Plan Name:_____ID#:_____

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? **Y___ N __**
IF YES, PLEASE NOTIFY THE RECEPTIONIST.

EXPRESS DOCS
WALK-IN URGENT CARE CENTER

PAYMENT POLICY

TO OUR PRIVATE INSURANCE PATIENTS:

If you have a yearly deductible on your health insurance policy that you have not met, payment for your visit will be due at the time of service. We will file your claim with your insurance company and apply your billed amount to your deductible. We will verify your deductible amount on the date of service for every office visit. Your patience during this process is appreciated. If we cannot verify the amount of your deductible, your insurance will be billed for the cost of the office visit. Any amount not paid by your insurance will be billed to you separately. Thank you for your cooperation in this matter.

TO OUR CASH/UNINSURED PATIENTS:

You must have a means of payment available to you at the time of service. If you cannot afford to pay a minimum fee at the time of service, you may seek care in the Emergency Room. The hospital receives government support to assist in low income patients.

TO OUR MEDICARE PATIENTS:

Under some conditions Medicare may not pay for services, procedures, or medications given in this office. Under these circumstances, you may be billed separately for these services. You must sign a waiver for this to occur and will be informed of the treatments which may not be covered at the time of service.

TO OUR MEDICAID PATIENTS:

If your Medicaid is assigned to another physician or medical office, we may need a referral number from them to treat you. A referral number lets your physician know what is being done for you and by whom. Under some conditions, we may be unable to collect a referral number from your physician. If this occurs, you may elect to wait and be seen at a later time by your primary doctor, have your Medicaid primary medical office changed to our facility or seek medical care in the Emergency Room.

Any payments denied by your financial institution will be assessed a $35.00 service fee in addition to original fees.

Please ask if you would like to arrange a payment plan for any amounts you will be billed. We will be happy to work with you.

_____ _____

Patient's Signature Patient's PRINTED Name

_____

Date

EFFECTIVE DATE: 2/19/2014

EXPRESSDOCS WALK-IN URGENT CARE CENTER

NOTICE OF PRIVACY PRACTICES - HIPAA

This notice describes how medical information about you may be used and disclosed, the privacy practices at our office, and how you can get access to the information. Please review it carefully.
We are required by law to:

- Maintain the privacy of protected health information.
- Give you this notice of our legal duties and privacy practices regarding your health information.
- Follow the terms of the notice currently in effect.

Described as follows are the ways we may use and disclose your health information except for the following purposes, we will use and disclose your health information only with your written permission.
You may revoke such permission at any time by writing to ExpressDocs.
TREATMENT: We may use and disclose your health information for your treatment and to provide you with treatment related health care services. For example, we may disclose your health information to doctors, nurses, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.
PAYMENT: We may use and disclose your health information so that others or we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give information to your health plan so that they will pay for your treatment.
HEALTH CARE OPERATIONS: We may use and disclose your health information to evaluate and improve our medical care and to operate and manage our office. For example, we may use and disclose information to a peer review organization or a health plan that is evaluating our care. We may also share information with others that have a relationship with you for their health care operation activities.
Please sign and date below to acknowledge receipt of this notice.

Patient's Signature/Date:_____

CONSENT FOR TREATMENT, PAYMENT, & HEALTHCARE OPERATIONS

In this document, "I" and "my" refer to the patient, and "Provider" refers to ExpressDocs. I consent to the use or disclosure of my protected health information by the Provider for the purpose of analyzing, diagnosing, or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations by the Provider. I understand the analysis, diagnosis, or treatment of me by the Provider may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. The Provider is not required to agree to the restrictions that I may request. However, if the Provider agrees to a restriction that I request, the restriction is binding on the Provider and I have the right to evoke this consent, in writing, at any time, except to the extent that the Provider has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information related to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I have been provided with a copy of the Notice of Privacy Practices and understand that I have a copy of the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of the Provider. The Provider reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

Patient's Signature/Date:_____

14530 S. Military Trl, Suite A1-A5, Delray Beach,FL 33484 / Phone: (561) 381-0260/Fax: (561) 381-0259

EXPRESSDOCS WALK-IN URGENT CARE CENTER

CONSENT FOR MEDICAL/BILLING INFORMATION RELEASE

PATIENT INFORMATION

First Name:_____ Last Name: _____

Date of Birth:_____SSN:_____

I, the above-referenced patient, hereby acknowledge and give authorization for the release and disclosure of medical records and billing information as follows:

RECORDS TO BE RECEIVED FROM:

Practice Name:_____ Phone:_____Fax:_____

Requested Documents: _____

RECORDS TO BE RELEASED TO:

1) Myself, the undersigned patient, via the following E-Mail address:_____

2) Name:_____

Company/Address:_____

Relationship: _____Phone:_____Fax:_____

3) Name:_____

Company/Address:_____

Relationship: _____Phone:_____Fax:_____

By my signature, I understand that the question of privacy between ExpressDocs Urgent Care, my attending physician, other physician(s), and the patient is waived. I fully understand that my medical record or billing information maintained in connection with the date(s) of service from inception until today may contain mental health, alcohol and drug abuse history, Human Immunodeficiency Virus (HIV) test results, or Acquired Immunodeficiency Syndrome (AIDS) information. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. Any medical records or billing information authorized to be disclosed hereunder are privileged and confidential and may be disclosed only on my authorization, except as required by law. Once this information has been disclosed to the authorized party above, I acknowledge that it may be subject to re-disclosure by the recipient and my privacy may no longer be protected. Only such records or information believed necessary for the purpose expressed shall be released and disclosed. I may inspect and arrange for photocopies of the record that are disclosed. If I refuse to sign this authorization, my medical record will not be released. I further understand that my records may not have been reviewed by the provider and therefore may not be considered as full and complete records for legal purposes. Should I require a legally verified and complete copy of your records, I will have my physician or legal representative (attorney), submit a request for such records in writing along with consent for release in order to comply with HIPAA regulations. This authorization is valid for one year from the signed date or until ___ /___ /___ . I understand that I may revoke this authorization at any time (except to the extent that action has already been taken in good faith reliance on this authorization) by submitting a revocation request to ExpressDocs Urgent Care.

By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health and billing information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health or billing information.

Signature of Patient or Guardian: _____Date:_____

Print Name: _____