Patient Registration Form

Patient Information

Patient Information			
Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address:.		Apt #	
City/State/Zip:			
Home Phone:	Cell Phone:	Work Phone:	
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) Voice Text		If Voice, Please Select Preferred Number: □ Home □ Cell □ Work	
Family Physician or Pediatrician:	Date of Birth:	Sex: □Male □Female	
Marital Status:	Social Security #:		
Employer Name:	Emergency Contact Name:		
Emergency Contact Phone:		Relationship to Patient:	

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor		
Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	
Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW)		
Email Address:	Can we leave a message regarding your medical care & test results? □ yes □ No	
Race (please select): □White □ American Indian or Alaska Native □Asian □Hispanic □ Black or African American □Native Hawaiian or Pacific Islander □Other □ Decline	Ethnicity (please select one): □Hispanic or Latino □Not Hispanic or Latino □Decline	
Preferred Language (please select one): □English □Spanish □Other		
Preferred Pharmacy Name & Location:		

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security g:	Policy Holder's Social Security g:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

____________________________ Date: __________

I certify that I read and agree to Premier Acute Care (PACS) payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to PACS all money to which I am entitled for medical expenses related to the services performed from time to time by PACS. I authorize PACS to release any medical information to my insurance carrier or third-party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency acquiring a 30% interest charge to your account. A **$40.00** returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from PACS by **text** or e-mail at the number or e-mail address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read a third party.
MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to PACS. I authorize ant holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of Premier Acute Care (PACS) Privacy Notice. ___________ (initials)

Signature of Responsible Party: **X**______________________________ **Date:** ______________

Printed Name of Responsible Party: **X**______________________________ **Date:** ______________

Medical RELEASE OF INFORMATION(HIPPA Release Form)

Name:______________________________ Date of Birth:______________________________

Release of Information

You expressly consent and agree that, in order to discuss or services your account(s)("the Accounts") or to collect amounts you may owe, PACS Urgent Care, and officers, agents, affiliates, employees, and affiliated or associated service providers and third-party debt collection agency associated therewith (collectively, "WE") may contact you by telephone at any telephone number associated with Accounts including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that we may also contact you by sending text messages, automatic dialing methods, system, or devices, and pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charge results.

I authorize the information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- ☐ Spouse:______________________________
- ☐ Child(ren):______________________________
- ☐ Parents:______________________________
- ☐ Other:______________________________
- ☐ **Information is not to be released to anyone**

This Release of Information will remain in effect until terminated by me in writing.

Preferred Contact Method

Please call: 0 My home 0 My work 0 My mobile______________________________

If unable to reach me: 0 You may leave a detailed message 0 Please leave a message asking me to return your call
Best time to reach me is ____________________

The above information is true the to best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize PACS Urgent Care to release any information required to process my claims.

Patient/Parent or Guardian Signature: ______________________________ Date:______________