PRESTON URGENT CARE FAMILY PRACTICE

PLEASE PRESENT YOUR INSURANCE CARD ON EVERY VISIT

YOUR COPAY IS DUE AT THE TIME OF SERVICE

Last Name: _____ First Name: _____ Middle In: ____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

S.S. #: _____ Date of Birth: _____ Age: _____

Marital Status: M S D W Sex: M F Driver's License#: _____

Email address: _____ Pharmacy: _____

Emergency contact: _____ Phone: _____

Whom we may contact in regards to medical information: (labs, x-rays, etc.): _____

_____

Race: _____ Ethnicity: _____ Dominant Hand: _____

Primary Care Physician: _____ Phone: _____

PRIMARY INSURANCE

Primary Insurance: _____ Policy Holder's Name: _____

Policy Holders S.S. #: _____ Policy Holder's DOB: _____ Sex: _____

SECONDARY INSURANCE

Primary Insurance: _____ Policy Holder's Name: _____

Policy Holders S.S. #: _____ Policy Holder's DOB: _____ Sex: _____

Do you sustain an injury at work?

Y N

Are you covered under an employer or union policy?

Y N

Are your injuries accident related?

Y N

Are you currently employed?

Y N

Have you ever served in the military?

Y N

Are you covered under any other health care plan?

Y N

Who is responsible for this bill? _____

I have received services by another provider for the condition for which I seek treatment today and I will promptly disclose any necessary information to my insurance carrier necessary to resolve any issues they may have. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature: _____ Date: _____

PRESTON URGENT CARE FAMILY PRACTICE

Practice Name: PRESTON URGENT CARE FAMILY PRACTICE Date: _____

Address: _____ Patient: _____

City, State, Zip: _____ ID#: _____

Phone: _____ Group#: _____

I, _____, understand that services rendered to me by PRESTON URGENT CARE FAMILY PRACTICE, are my financial responsibility and that the provider will bill my insurance company, _____ as a courtesy. I authorize my insurance company to pay my benefits directly to PRESTON URGENT CARE FAMILY PRACTICE and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by _____.

I authorize the provider to release any information necessary to adjudicate the claim and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to PRESTON URGENT CARE FAMILY PRACTICE within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize PRESTON URGENT CARE FAMILY PRACTICE to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize the provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified or denials.

Dated: _____ Witness: _____

_____ _____

Signature of policyholder Patient or Guardian