HealthcareOne
Urgent Care and Family Practice

PLEASE FILL OUT THE ENTIRE FORM.

REGISTRATION FORM

Please Print

Date: _____PCP: _____Pharmacy: _____

Reason for Visit:

_____

First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____ SSN: _____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____Cell: _____ Work: _____

Email Address: _____

Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated □Other
Employment Status: □ Employed □ Not Employed □ Retired
Occupation: _____

Information we are required to ask
We are required by the Federal Government to ask and collect information on race, ethnicity, employment status and language preference. We appreciate you providing us with this information.

Race: □Am. Indian/Alaska Native □Asian □Black or African Am. □Hispanic
□Native Hawaiian or Pacific Islander □White □Decline

Ethnicity: □Hispanic or Latino □Not Hispanic □Decline

Language Preference: □English □Decline □Other, please specify _____

Sexual Identification:
□ Straight or heterosexual □ Homosexual □ Bisexual □ Don't know □Decline
□ **Other**_____

Gender Orientation:
□ Male □ Female □ Transgender □Decline
□ **Other**_____

PARENT OR GUARDIAN (LEAVE BLANK IF NOT APPLICABLE)

Name: _____
Relationship: _____ Phone: _____

INSURANCE CARD HOLDER INFORMATION

Insured Name (Policy Holder): _____

Home Phone: _____ DOB of Insured: _____
Sex: □ Male □ Female Insured SSN: _____
Employer of Insured: _____ Work Phone: _____

EMERGENCY INFORMATION (nearest relative or friend)

Emergency contact person: _____ _____
Relationship to Patient: _____ Phone number: _____

We cannot file insurance without a copy of your insurance card(s) for verification of coverage.

I hereby authorize my Nurse Practitioner to furnish my insurance company or its representative or permit my insurance company or its representative to review any information requested with respect to any illness or accident, medical history or copies of hospital and medical records. A photo static copy of this authorization shall be considered as valid as the original. I hereby authorize payment directly to my Nurse Practitioner for this illness or injury, of the physician(s) or surgeon(s) benefits otherwise payable to me, but not to exceed my indebtedness to said Nurse Practitioner for all my charges whether or not covered by this assignment. The responsible party hereby agrees that the Nurse Practitioner's office or the party responsible for the billing of these services may check credit with a source to obtain credit information. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services. This release may include information which may be considered a communicable venereal disease which may include, but not limited to diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS). I understand all of the above and hereby state all the information is correct to the best of my knowledge. My signature indicates that I have read the above and grant the request of authorizations. I hereby consent to all tests, treatment, procedures and care provided by this institution and Nurse Practitioner.

PLEASE NOTE: PAYMENT IS DUE AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

_____ **DATE:** _____

Patient or Authorized Person's Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OR PRIVACY PRACTICES

The attached Notice of Privacy Practices describes how Healthcare One medical clinic, retail pharmacies, and outpatient service providers and the individual members of its professional staff may use and disclose your medical information and how you can get access to this information. Please review it carefully.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:
A complete copy of the Facility's Notice of Privacy Practices is attached hereto and posted in the Facility. By signing below you acknowledge that you have received a copy of the Facility's Notice of Privacy Practices.

_____ **DATE:** _____ **Time:** _____**(a.m./p.m.)**

Signature of patient

IF PATIENT IS A MINOR OR INCOMPETENT: I hereby acknowledge that I have received a copy of the Facility's Notice or Privacy Practices on behalf of the patient.

_____ **DATE:** _____ **Time:** _____**(a.m./p.m.)**

Relationship to patient

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CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ SSN: _____

DOB: _____

I, _____, give my permission to have any/and or all of my medical information, including financial, released to the following person(s):

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

Relationship: _____ Relationship: _____

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

Relationship: _____ Relationship: _____

Patient Signature: _____ Date: _____

Witnessed By: _____ Title: _____

APPOINTMENT AND NO SHOW LATE POLICY

Appointment No Shows

A NO SHOW appointment is a missed appointment without letting our office know 24 hours before your scheduled appointment. If your appointment is scheduled for a Monday, we require you contact us by the Saturday before your appointment.

• The first no show will result in a call or letter reminding you that you missed your appointment and will need to reschedule for another day.

• The second no show will result in a $25 charge (not covered by insurance) to the patient. This no-show fee must be paid before an appointment will be scheduled.

• The third no show will result in allowing you to be seen on a walk-in basis only.

Late Policy

Everyone is late at some time. Please call us ahead of time so that we can try to modify your appointment or reschedule to help with delaying anyones care.

• Patients arriving early or on time will be seen in the order they were scheduled.

• Any patient arriving 15 minutes late will be asked to reschedule.

_____ _____

Signature of Patient (18 years and older) Signature of Parent or Guardian (if applicable)

_____ _____

Print Name of Patient Print Name of Parent or Guardian

_____

Date