NEIGHBORHOOD urgent care

REGISTRATION FORM

PLEASE PRINT **All Fields Are Required**

Today's Date:	**Primary Care Physician:**		**Pharmacy:**

PATIENT INFORMATION

Patient's Name **Last:** **First:**		**MI:**	**Marital status:** **M** **S** **Child**

MI

Social Security #:	**Date Of Birth:**	**Phone #:** **Cell No:**	**Sex:** **M** **F**

Address:	**City:**	**State:**	**Zip**

How did you hear about us?	**EMAIL:**

Reason for Today's Visit:	**Parental Consent: List name(s) that may bring in child for medical treatment:**

Parent/Guardian:	**Social Security #**	**Date of Birth:**	**Relationship to patient:**

INSURANCE INFORMATION

Primary Insurance (Name):			
Subscribers Name:		**Subscribers SS#:**	
Date of Birth:	**Group #:**	**ID or Policy #:**	**Copayment $:**
Secondary Insurance (Name)			
Subscribers Name:		**Subscribers SS #:**	
Date of birth:	**Group #**	**ID or Policy #**	

The above information is true to the 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 Velocity Medical LLC DBA Neighborhood Urgent Care or insurance company to release any information required to process my claims.

HIPPA PRIVACY AUTHORIZATION: By signing this authorization you acknowledge and agree that Velocity Medical DBA Neighborhood Urgent Care, may use or disclose my Information for medical purpose only. By signing this authorization you agree that Velocity Medical LLC DBA Neighborhood Urgent Care, may disclose your personal health care information to any doctor's office that request such information and also to

_____(persons name, relative that we can discuss your information with).

Further, by signing this authorization you acknowledge that you have been offered a copy of and have read and understand Covered Entity's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA.

Further, by signing this authorization I give Neighborhood Urgent Care permission to bill my Insurance Company/s for treatment at this Facility and I understand that I am responsible for any amount that my Insurance Company deems me responsible for.

_____ _____

Patient/Guardian signature **Date**

EMERGENCY CONTACT# & RELATIONSHIP-_____