# Patient Registration

Today's date_____

**Have you been here before? Y/N  Reason for today's visit:**_____

First Name:_____ Last Name:_____ MI:_____

Address:_____City:_____State:_____Zip:_____

Home#(  ) _____ Work # (  )_____Cell# (  )_____

DOB:_____/_____/_____  Social Security #:_____ -_____-_____  Gender: M  F

Preferred Language:  English  Other:(please specify)_____

Emergency Contact:_____Phone#_____

Pharmacy_____How did you hear about our office?_____

Is this Workers Comp/Auto Accident Y/N Responsible party?_____

Primary Care Physician:_____

Do you want your visit sent to your Primary Physician office?  Y  N

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**Responsible Party/Guarantor  check if same as patient** ☐

Name:_____MI:_____DOB:_____

Gender  M/F  Relationship to Patient:_____

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**Insurance Coverage**

**Primary Ins. Company** _____Policy#_____

Subscriber/Member name:_____Insured SS#_____

Group#_____ Relationship to patient_____DOB of insured:_____/_____/_____

**Secondary Ins. company**_____Policy#_____

Name of Insured:_____Insured SS#_____

Group#_____Relationship to patient:_____DOB of insured:_____/_____/_____

**The above information is true and correct to the best of my knowledge.**

_____  _____

Patient/Legal Guardian Signature  Date  Patient/Legal Guardian Printed Name

**Financial Responsibility Form**

At Medicus Urgent Care, we strive to give you the best possible care. In order to serve this purpose, it is important that you understand the process of reimbursement. Please read this Financial Responsibility Form and sign at the bottom to acknowledge that you understand your accountability.

**ANY CHANGES to your DEMOGRAPHICS or INSURANCE must be brought to our attention, BEFORE the Doctor's visit. Failure to do so may result in the patient being responsible in FULL for ANY & ALL charges for services rendered. The CORRECT information is CRITICAL especially for proper billing of laboratory test that may be required and ordered. If this information is incorrect or not current the patient will be responsible for the bill in its entirety. Our office CANNOT guarantee that your carrier will pay your claim. If your claim is denied by your carrier, the obligation for payment is the responsibility of the patient. Our office will not enter into a dispute with the insurance carrier over the claim. We will however, be happy to assist wherever possible.**

**Outstanding payment due for over 30 days may incur Interest Charges of $5.00 for every 30 days that the payment remains overdue. Billing statements will be mailed every 4 weeks.**

**INSURANCE COVERAGE**

It is your responsibility to be aware of your insurance coverage, including but not limited to policy provisions, exclusions and limitations, and authorization requirements. This information can be obtained by contacting your insurance carrier. We attempt to verify that your coverage is valid at the time of your visit. However, if your coverage is not in effect at the time of the visit, the financial responsibility for any payments due will be yours.

**CO-PAYMENTS, CO-INSURANCES, AND DEDUCTIBLES**

Co-payments and co-insurances are your responsibility. Your insurance company expects us to collect them from you at the time of service. Please understand that you will be expected to pay your co-payment before your appointment for each and every date of service. You are responsible for your deductibles. The deductible is determined by your individual contract with your insurance carrier. We may not have information about each person's deductible amount, or how much of it has been met. You will be responsible for finding out all information regarding your deductible prior to your appointment with our office.

**SELF PAYMENT / SELF-PAY**

All cash patients and patients present without valid insurance information are considered self-pay patients. All self-pay patients are required to pay at the time service is rendered. Please be prepared to make this payment with the front desk personnel prior to your visit. Should you have insurance but are unable to provide valid information at the time of your visit, you will be expected to pay in full at time of service until your insurance information is on file.

**Laboratory Bills**

I understand that if laboratory testing is performed by Medicus Urgent Care the outside reference laboratory will bill me directly. I understand that fee schedule (cost) for laboratory test performed by Medicus Urgent Care shall be available to the patient upon request.

**We understand that financial circumstances vary from patient to patient. If you are unable to pay your patient due balance in full, you must call our business office at 570-969-0663 to make payment arrangements.**

**Medicus Urgent Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.**

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

**Medicare Lifetime Signature On File( Medicare patients only)**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Medicus Urgent Care and it's physicians for any service furnished to me by that physician. I authorize release to the Centers for Medicare and Medicaid Services and its agents any medical information about me needed to determine the payments for related services.

Signature: _____

**FMLA and other Disability Paperwork**

• There is a charge of $15 per form, payable prior to these forms being completed. Understand that these forms can be quite complicated and tedious to fill out. Please provide pertinent information like dates of disability and return to work date. Please allow the office 5 business days in which to review your medical record for the information requested, complete it, copy, mail or fax it.