

REGISTRATION FORM

(Please Print)

Today's date:				PCP:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: ()		
P.O. box:		City:		State:		ZIP Code:	
Employer:		Employer ph. # ()			Cell # ()		
PHARMACY:				#			
If we can contact you via email put email address here:							

INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date: / /	Address (if different):			Home phone no.: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:		Employer:	Employer address:			Employer phone no.: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance		<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	
<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/>	<input type="checkbox"/> Other			
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:		Policy no.:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):			Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

IN CASE OF EMERGENCY							
Name of local friend or relative (not living at same address):				Relationship to patient:		Home phone no.: ()	Work phone no.: ()
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 MED MART URGENT & PRIMARY CARE or insurance company to release any information required to process my claims.							
_____ <i>Patient/Guardian signature</i>						_____ <i>Date</i>	

MED MART URGENT & PRIMARY CARE FINANCIAL POLICY

Insurance is not payment in full and should not be treated as such. We will file your insurance as a courtesy for you, but we ask for your cooperation by providing us with the most current information.

In the event your insurance denies, suspends the claim for information from you, or applies to the amount to your deductible or co-insurance, the balance will be due immediately.

*****Please refer to the policy below that pertains to you. If you are not able to adhere to these policies you will be asked to reschedule.**

- 1) “Self pay” patients must pay the visit in full at the time of service. If payment in full is not possible, financial arrangements must be made with the staff prior to seeing the provider. A “down payment” of \$100.00 for new patients and \$75.00 for established patients will be required before being treated. The full balance will be due immediately upon check out after services are rendered. Payments must be in the form of cash, or credit card. No checks!**
- 2) Patients with co-payments listed on their insurance cards must pay that prior to being treated by the provider.**
- 3) Medicaid adults 21 years of age and older must pay a \$3.00 co-pay prior to being treated.**
- 4) Patients with insurances with which we do not participate will be expected to pay in full at time services are rendered. Refer to #1 listed above.**
- 5) Patients who have been involved in an automobile accident will be able to file to their health insurance, but will not be allowed to file to a third party, such as Nationwide, GMAC etc. If your insurance denies your claim due to your being involved in an automobile accident, then you are responsible for paying the bill and filing to your third party carrier. (see Office Manager if you have questions)**
- 6) Medical records requested by patients will be charged .25c per page. Medical records requested by other physicians will be free of charge.**
- 7) There will be a \$25.00 RETURNED CHECK FEE. All fictitious and fraudulent check writers will be prosecuted.**
- 8) Carolina Access Medicaid patients require prior approval from their PCP prior to being treated. It is your responsibility to obtain “authorization”, but as a common courtesy we will make an attempt to contact your PCP prior to treatment. If we are unable to contact your PCP then a document must be signed by the patient or guardian of the patient stating they will be responsible if authorization is not given.**
- 9) We do not accept Out-Of-State Checks, Starter Checks or Checks from New Patients.**

Date:

Signature of Patient or Responsible Party

ACKNOWLEDGEMENT OF RECEIPT OF MED-MART URGENT CARE

HIPPA POLICY

We are required by law to maintain the privacy of, and provide individuals with, the notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to, or questions about this form, please ask to speak with our compliance officer.

Signature below is the only acknowledgement that you have read a copy of the Notice Of Privacy Practices. You may have a copy I to keep upon request.

Date:

Signature of Patient or Responsibility Party

MED MART URGENT & PRIMARY CARE OFFICE POLICIES FOR PATIENTS

- ✓ We take our last patient 30 minutes prior to closing.
- ✓ We see patients 2 years of age and older
- ✓ Please be aware that you may receive a bill or notice from another company for labs performed at this office.
- ✓ We perform physical exams; however, we require that you bring the physical form to your visit (if you have a form that needs to be filled out) and if applicable any previous medical records.
- ✓ If you are a new patient and need a medication refill, you must bring your most recent medication bottle with you to your visit or be able to give a pharmacy name for verification of the prescription.
- ✓ We are unable to release medical information regarding the patient, unless patient is a minor, to anyone else other than authorized persons stated below by the patient (see HIPPA law).

1. _____
2. _____
3. _____
4. _____

I have read and agree to the terms described above:

Date:

Signature of Patient or Responsible Party

