REGISTRATION 3/10/10 jd

How did you find out about our practice?: _____

PATIENT'S CONTACT INFORMATION

Patient:_____
(Last Name) (First Name) (MI)

Sex: M / F Date of Birth:_____ SS#:_____
(If used as Insurance ID #)

Street Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone: _____

Cell Phone: _____ Email: _____
(Please supply for important information and updates)

Patient Relationship to Insured: SELF / SPOUSE / CHILD / OTHER:_____

PRIMARY Insurance Company's Name: NONE / _____

SECONDARY Insurance Company's Name: NONE / _____

INSURED'S INFORMATION *(if different than patient)*

Insured's Name:_____
(Last Name) (First Name) (MI)

Insured's Sex: M / F Insured's Date of Birth:_____ Insured's SS#:_____
(If used as Insurance ID #)

Insured's Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone: _____

Cell Phone: _____ Email: _____
(If you would like to receive our email updates)

EMERGENCY CONTACT

In case of emergency, who should be notified?:_____

Relationship to patient:_____ Phone:_____

CONSENT FOR TREATMENT

EMC provides Urgent Care services. At the time of your visit, we collect an initial payment toward uncovered expenses. We will file with your insurance company for your health insurance benefits including appeals and filing with secondary insurance as necessary. Any remaining balances (ex. deductible, coinsurance, copay balance, out-of-pocket and denied charges) will be billed to you. We cannot anticipate what specific rates your carrier will apply. Should payment not be received from your insurance carrier, the patient or responsible party will be responsible for the balance.

I understand that **I am financially responsible** for all charges not paid or otherwise adjusted by insurance (copay, deductible, coinsurance, out-of-pocket, and any amounts denied by my insurance). I give authorization for payment of insurance benefits for service rendered to be made directly to EMC. I authorize EMC to release all information necessary to secure payment for my medical care. EMC offers significant discounts to those paying in full on the date of service and for care paid by employers through the Employee Care Plan. Additional fees may apply for late payments and/or to cover the costs of collecting balances owed.

I consent to reporting requirements by the government including ImmTrac (Texas Immunization Registry), police, court, legislation (local, state, and national). My records may be shared with others involved in my care (ex. pharmacies, doctors, hospitals) and by third party payors (ex. medical insurance) for quality measures or to obtain payment.

I give consent for evaluation and treatment. I acknowledge that I have read and understand the terms and conditions of this agreement and that I may receive a copy upon request. Notice of Privacy Practices posted and copy available upon request.

Patient (or responsible party and relationship to patient) Date

4/1/12 jmf