Patient Information, HIPAA, Financial and Consent Form

Date ____/_____/_____ Date of Birth ___/____/_____ Age_____

First Name _____ Last Name _____

Address_____ City_____ State ___ Zip _____

Phone Number_____ Email_____

Social Security Number_____ Race_____ Ethnicity: __Hispanic __Non-Hispanic Decline __

Occupation? _____Employer_____

Emergency Contact:_____Phone:_____Relationship:_____

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INSURANCE SUBSCRIBER INFORMATION ____ Check if same as patient information

Name:_____ Date of Birth: _____

Address:_____

Social Security:_____ Phone Number: _____
Relationship: _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

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IN ORDER TO CONTROL YOUR COSTS OF BILLING, OFFICE VISIT CHARGES NEED TO BE PAID AT THE TIME OF THE VISIT. **SEND-OUT LABS ARE BILLED SEPERATELY BY THE LAB SERVICE. THIS IS AN ADDITIONAL CHARGE**.

I authorize the release of any medical information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits to include major medical benefits to which I am entitled including Medicare, private insurance and other agency reimbursements to this center. This assignment will remain in effect until revoked in writing by me. A copy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said- insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

I, _____, acknowledge receipt of the Broken to Better Urgent Care Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information. **The notice is located on this clipboard for your review**. I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available by mail or from the official website at www.betteruc.com I voluntarily consent to all and any health care treatment, examinations, and diagnostic procedures provided by the Broken to Better Urgent Care and associated physicians, clinicians, and staff.

Signature: _____ Date:_____