# *Welcome To Our Office*

PLEASE PRINT and COMPLETE ALL PARTS

MAITLAND AVE. URGENT CARE FAMILY PRACTICE

Patient Number _____ Today's Date _____

**PATIENT NAME: (This section refers to PATIENT ONLY)**

Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ S.S.N. _____

Date of Birth _____ Age _____ Sex _____ Email _____

Employer _____ Work Phone _____ Spouse _____

Relationship to Responsible Party ☐ Self ☐ Spouse ☐ Son ☐ Daughter ☐ Other

**RESPONSIBLE PARTY: (Person who should receive the bill)**

Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Social Security # _____

Date of Birth _____ Age _____ Employer _____

**HOW DID YOU HEAR ABOUT US?:** _____

**REFERRING PHYSICIAN NAME (PCP):** _____ Phone: _____

**INSURANCE: (Please complete thoroughly. We will need a copy of your insurance card.)**

Primary Insurance _____ Address _____

City, State, Zip _____ Phone: Area ( ) _____

Primary Insured Person _____ ID/Policy # _____ Suffix _____

Group # _____ Employer _____

Co-payment $ _____ Auto Injury ☐ claim # _____

Work Comp ☐ Claim # _____ Other Injury (Specify) _____

What lab do you use? Quest _____ Labcorp _____ Other _____

**NOTIFY IN EMERGENCY:** (NOT LIVING WITH YOU)

Name _____ Relationship _____ Phone _____

**CONSENT FOR TEST RESULTS** I give Maitland Ave. Urgent Care permission to leave all X-ray, lab results, test results, and other medical information and advice on: (check all that apply)

☐ Voice mail at work ☐ Answering machine at home ☐ Other _____ ☐ Do not leave message

I hereby acknowledge that I have received a copy of Maitland Ave Urgent Care Notice of Privacy Practices, and authorize the release of any medical information and payment of medical benefits to the undersigned physician or supplier for services necessary to process a claim. I agree to be responsible for any deductible, co-insurance, co-pay, or any other balance not paid by my insurance.

Signature: _____ Date: _____

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES.**

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ THEM OR DECLINED THE OPPORTUNITY TO READ THEM AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT THIS FORM WILL BE PLACED IN MY PATIENT CHART AND MAINTAINED FOR SIX YEARS.

PATIENT NAME _____ DATE _____ PARENT OR GUARDIAN _____ DATE _____

SIGNATURE _____

**Release of Medical Information**

Staff from Maitland Ave. Urgent Care may leave a message with a family member or other person who answers the phone when the patient is not home or unavailable. The Privacy Rule Permits covered entities to disclose limited information to family members, friends, or other persons regarding an individual's care, even when the individual is not present. Staff, will however, use professional judgement to assure that such disclosures are in the best interest of the individual and limit the information disclosed.
http://www.hipaaps.com/cgi-bin/viewanswers.cgi See 45 CFR 164.510(b)(3).

# MAITLAND AVE. URGENT CARE

## FINANCIAL POLICY

**IF YOU HAVE ANY QUESTIONS ON THE FOLLOWING FINANCIAL POLICY PLEASE LET THE OFFICE STAFF KNOW BEFORE SIGNING.**

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. Be advised that if there is any procedure not covered by your insurance company, you will be responsible for payment. Additional charges may apply for after hours, evenings, weekends and holidays.

**PAYMENT IS DUE AT THE TIME OF SERVICE**

This includes all copays, deductibles, and any charges or procedures that are not covered by your insurance. We do not make payment plans, unless arrangements are made beforehand with an office manager. In an event where there is a financial agreement signed, failure to comply with that agreement will result in discontinuation of future services. We gladly accept cash, local checks, and most credit cards (except for American Express).

We participate with many insurance plans. Patients with other private insurance or no insurance are required to pay in full at the time of service. As a courtesy we will file certain insurance for you only after benefits and eligibility have been verified.

Please understand that your insurance policy is a contract between yourself and your insurance company. We are not involved in that contract. It is beneficial for you to read and understand your policy fully. It is the patient's responsibility to know which labs their insurance is affiliated with. If you are not sure which lab you should use, please call your insurance company. If a claim has been filed correctly on your behalf and not paid within 45 days by your insurance carrier, you will be responsible to pay the balance. **Should any financial transaction not clear your banking institution, you will be responsible for all fees incurred both from your bank and this office.**

The adult who accompanies a minor is responsible for payment at the time services are rendered, regardless of their relationship to the patient. If someone other than yourself accompanies your child, please make sure that the authorized adult is financially prepared.

If this account should become delinquent and past due after ninety (90) days, I agree to pay all costs of collection including, but not limited to, court costs, sheriff fees and collection costs as may be necessary

**I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY.**

Patient _____ Date _____

Signature of Parent or Guardian _____