STATClinix URGENT CARE

Patient Registration Form

Patient Name (First, Last Middle)_______________________________________**Date of Birth**_________________

SSN:____________________________ **Gender:**___________________________ **Marital Status:**_______________

Primary Care Practice/Physician:_________________________________ **PCP Phone:** _________________________

Patient Representative/
Person completing form If Not Patient:____**Relation:**________________

Mailing Address: ____**Apt #:**___________

City: ____ **State:** _____________ **ZIP:**_______________________

Home Phone#: ___________________________ **Cell#:**__________________________**Work#:**___________________

Email Address: ____

Activate StatClinix Patient Portal Account ____**Yes** ____**No**
View your test results, health tips, visit information, schedule appointments and more on the StatClinix Patient Portal!

Ethnicity/Race:___________________________________ **Preferred Language:** ____________________________

*****Information collected for census purposes******

***Emergency Contact:**___________________________ ***Emergency Contact Phone:**________________________

Advance Directive Information: Do You have a Living Will? ☐Yes ☐No ☐Refused
Do you have a Healthcare Power of Attorney? ☐Yes ☐No Name:____

Preferred Pharmacy: ____ **Phone:**___________________________

Address/Cross Streets:____

Minors Only

Mother's Name (First, Middle, Last)____________________________________**Date of Birth**_________________

Father's Name (First, Middle, Last) ____________________________________ **Date of Birth** _________________

INSURANCE and SUBSCRIBER INFORMATION
******Please provide your insurance card(s) AND Photo ID to the FRONT OFFICE******

Primary Insurance	Secondary Insurance
Insurance Company:______________________________	Insurance Company:______________________________
Name of Insured:_________________________________	Name of Insured:_________________________________
Relation to Insured:_______________SSN:____________	Relation to Insured:_______________SSN:____________
Address:_______________________________________	Address:_______________________________________
City/State/Zip__________________________________ _	City/State/Zip__________________________________ _
Policy #_______________________________________	Policy #_______________________________________
Group #_______________________________________	Group #_______________________________________

I authorize release of my personal information including medical treatment, scheduling and billing information to the individuals listed below.

Name	Relationship

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Signature of Patient/Patient Representative:____Date:____________

CONSENT FOR MEDICAL TREATMENT

I, the patient or the authorized representative of the patient, hereby consent to any examination, evaluation and treatment provided for any illness, injury, or other health concern affecting me at any time I present at StatClinix Urgent Care ("StatClinix") for medical care. These services may include but are not limited to: laboratory procedures, x-ray examinations, review of external pharmacy information and medical and/or surgical treatment or procedures.

FINANCIAL POLICY

1. All patients must provide accurate and complete personal and insurance information prior to being seen by the physician, physician assistant, nurse practitioner or other medical care provider/practitioner.
2. Payment is required at the time of service. StatClinix accepts payment by cash, check and credit/debit card.
3. StatClinix will gladly file a claim with your insurance company; however, it is your responsibility to comply with all pre-determination, pre-authorization and/ or notification requirements as may be required by your insurance plan. While many of the services provided by StatClinix may be covered benefits of your insurance plan, how these benefits are paid by your insurance provider and/or whether or not certain services are considered to be non-covered services is determined strictly by your insurance provider and not by StatClinix. It is your personal responsibility to understand the limitations and exclusions of your insurance plan, as well as to understand your co-pays, deductibles, in-network and out of network coverage including any and all applicable limitations, inclusions and/or exclusions.
4. StatClinix requires that the guarantor agree to be personally liable for all balances due or that may become due related to today's visit.
5. The fees for StatClinix services are reasonable and customary fees for this region and specialty. If the Patient's insurance company reimburses at a different rate than what is billed by StatClinix, the Patient may be responsible for any balance remaining.
6. StatClinix may charge reasonable fees for services related to your account including, but not limited to, returned check fees, interest on unpaid accounts, and medical record copies.
7. Should it be necessary to forward an account balance to a collection agency, the guarantor agrees to assume financial responsibility for reasonable collection costs.
8. StatClinix may disclose all or part of a patient's medical or financial records (including information related to alcohol and drug abuse, mental health diagnosis and treatment, HIV related or other communicable disease related information) to third parties to obtain payment for services provided.
9. The Patient's personal information will be updated at least one time per year to verify the information on file is accurate. It is the responsibility of the Patient to notify StatClinix of any changes of the personal and/or insurance information provided on this form.
10. Federal laws require that StatClinix submit every claim to an insurance company accurately and report the exact services performed and the exact reason for performing them. It is insurance fraud to change this information in order to try to obtain payment on a claim from an insurance company.

I agree that in the event my insurance provider does not pay for some/all of the charges associated with and incurred for today's visit, I will pay any remaining balance due and that balance will be my personal financial responsibility. I understand that this only applies to StatClinix procedures and charges and that this excludes any and all charges incurred from third party entities as a result of laboratory testing, durable medical equipment, etc. I understand that this Medical Treatment and Financial Agreement is and will be valid for any and all services provided by StatClinix effective from the date this Medical Treatment and Financial Agreement is signed by me and does not expire unless and until I inform StatClinix directly that I no longer wish to have this Medical Treatment and Financial Agreement in effect.

I have been given the opportunity to read StatClinix Notice of Privacy Practices and have had any questions addressed concerning that policy.

I have received a copy of the StatClinix Patient Rights and Responsibilities.

Signature of Patient/Patient Representative:____Date:____________