UrgentMED

UrgentMED.com

Date : _____

Name: _____ _____ _____
Last First Middle

Date of Birth: ___ / ____ / ____ **Social Security Number:** _____ **Gender:** □ Male □ Female

Address: _____
Street City State Zip

Home Number: _____ **Cell Number:** _____

Email Address: _____

Emergency Contact:
Name: _____**Phone Number :** _____**Relationship:** _____

If under 18, list the financially responsible party:
Name: _____**Phone Number:** _____**Relationship:** _____

How did you hear about us? (Google, Yelp, Friend, Drive by, Employer, etc): _____

Are you presently under the care of a physician? ☐ No ☐ Yes, Physician's Name: _____

Do you have any allergies or reactions to medications? ☐ No ☐ Yes, which one? _____

Do you have any major medical conditions? ☐ No ☐ Yes, list: _____
_____

What current medications are you taking?

Medication(s)	Dosage	Frequency

MEDICAL SERVICES AGREEMENT

(READ CAREFULLY BEFORE SIGNING)

PATIENT NAME: _____

1. **MEDICAL CONSENT**: I consent to any medical treatments or procedures that may be performed which may include but is not limited to medications, injections, taking of medical photographs, laboratory procedures, x-rays, and/or emergency services provided to me under the general instructions of the health care workers of Anaheim Urgent Care, Inc. and all its Associated Affiliates (herein referred to as "UrgentMED"), assisting my care.
2. **FINANCIAL AGREEMENT:** I understand that all charges are due at the time of service**.** I agree to pay UrgentMED for all charges for healthcare services provided to me. Acceptable forms of payment include Cash or credit card. If I am a non-insured patient, I agree to pay for my visit in full at the time of service. If UrgentMED is a participating provider with my insurance company I understand that my co-pay, coinsurance, deductible and/or any outstanding balances are due at the time of service. I understand that my insurance policy is a contract between myself and my insurance company--UrgentMED is not involved. I also understand that I am financially responsible for any services not covered by my insurance company**.** When my spouse or a financial guarantor signs this agreement, the spouse or the financial guarantor shall be jointly and individual liable with me. Should my account(s) be referred to an attorney or a collection agency for the collection, the undersigned shall pay the actual attorney's fees and collections expenses incurred in addition to the other amounts due. Unpaid accounts referred to outside agencies for collection shall bear a reasonable interest from the date of referral.
3. **INSURANCE AUTHORIZATION AND RELEASE:** I request that payment of authorized benefits, including Medicare, and any other government sponsored program, private insurance, and any other health plans be made to UrgentMED for any services furnished by that provider. To the extent necessary to coordinate my health care or determine liability for payment and to obtain reimbursement for services rendered, I authorize UrgentMED to disclose portions of or all of my records, including my medical records to any person or corporation which is or may be liable for all or any portion of UrgentMED charges, including but not limited to insurance companies, health care service plans, governmental agencies, or worker's compensation carriers. I authorize UM to act as my agent to help me obtain any required pre-certification as well as acting as my agent to help me obtain payment from my insurance companies. I authorize my insurance companies to give UrgentMED any information required to fulfill this function. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.
4. **RELEASE OF MEDICAL INFORMATION:** I hereby authorize UrgentMED to release my medical health records to my primary care physician, if requested, to allow for continuity of care and any practitioner or hospital which I may be referred to assist in my care.
5. **NOTICE OF PRIVACY PRACTICES:** By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* which provides how we may use and disclose your protected health information. We encourage you to read it in full.
6. **IN-HOUSE PHARMACY:** For my convenience, UrgentMED can dispense some prescription medication(s) necessary to treat my medical condition(s). I understand that my insurance will not be billed for medication(s) dispensed and are an additional charge. If I prefer to use an outside pharmacy, a prescription can be provided to me at no additional charge.
7. **PERSONAL VALUABLES:** UrgentMED shall not be liable for the loss of or damage to any personal property.
8. **CREDIT CARD AUTHORIZATION**: Our billing team will send a claim to your insurance company shortly after your visit. Once the claim is processed, your insurance company will send us a statement with the amount you owe. For your convenience, we will charge the credit/debit card you have left on file with us. There will be approximately 15 days from the time you receive the statement to the time your card is charged. If you would like to make other arrangements to pay off the balance or have questions, please contact us before the date on your statement. Our billing team's email address and phone number will be listed on the statement. By signing this section you are consenting to leave a credit/debit card on file with UrgentMED and your card will be charged for any remaining balance you may owe. Your information will be stored using secure and encrypted software by Chase Merchant Services. I certify that I am an authorized user of this card and agree with my card being charged as long as the transaction(s) correspond(s) to the terms indicated in this authorization form. I understand that this authorization will remain in effect until I cancel it in writing.

_____	_____	_____
Card Holder Name	**Signature**	**Email Address**

UrgentMED and the patient or the patient's representative, hereby enter into this agreement. The undersigned certifies that he/she has read and agrees to the foregoing and is the patient, the patient's representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

_____	_____		_____	_____
Signature of Patient	**Date**	**or**	**Signature of Patient's Representative**	**Date**
_____	_____		_____	
Medical Practice's Representative	**Date**		**Name & Relationship of Representative to Patient**	