Southern Care WALK IN CLINIC

Patient Registration Form

PATIENT INFORMATION

Patient Name: _____

Address: _____

City, State, Zip _____

Phone Number: Home: _____ Cell: _____

Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Gender: ☐ Female ☐ Male

Social Security #: _____ - _____- _____ Date of Birth: _____ / _____ / _____

Email Address: _____ ☐ Opt out of Email Communications

Pharmacy Name: _____

Pharmacy Address: _____

Employment Status: ☐ Employed ☐ Unemployed ☐ Student

Employer: _____

Emergency Contact: _____

Phone Number: _____

Relation to Patient: _____

RESPONSIBLE PARTY INFORMATION (Information Used For Patient Balance Statements)

☐ **Check Here if Same As Patient**

Responsible Party: _____

Address: _____

City, State, Zip: _____

Phone Number: Home: _____ Cell: _____

Gender: ☐ Female ☐ Male

Social Security #: _____ - _____- _____ Date of Birth: _____ / _____ / _____

Relationship to Patient: _____

PRIMARY INSURANCE INFORMATION

Name of Insured: _____ Patient Relationship to Insured: _____

Insurance Company: _____

Subscriber ID: _____ Group ID: _____

Do you have a secondary insurance? ☐ Yes ☐ No

RELEASE OF PROTECTED HEALTH INFORMATION

I authorize my protected health information to be released to the following individuals:

_____

_____

Consent for Treatment

I hereby authorize OHP Walk-In Clinics LLC to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medications, the review of any previously prescribed medications (by OHP or other medical providers), the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which in the judgment of the attending physician or their assigned designees may be considered medically necessary or advisable.

I understand that this is given in advance of any specific diagnosis or treatment and that those services are voluntary and that I have the right to refuse these services. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation. A photocopy of this consent shall be considered as valid as the original.

Healthcare operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care of treatment and the quality of that care.

_____ **Initial**

Financial Agreement

Payment includes but is not limited to: the authorization of payment directly to OHP Walk-In Clinics LLC of the benefits otherwise payable to me. I hereby acknowledge the release of my medical records to their party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury to my employer or designee understand that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks.

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you are responsible for your co-pay and or percentage, which the insurance is not responsible for on the day of your visit. It is the patient's responsibility to obtain any necessary referral forms from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient/guarantor we will place your account with a collection agency, which will leave you liable for any additional charges incurred.

_____ **Initial**

Notice of Privacy Practice

I acknowledge that this office, upon request, has available to me a copy of its Notice of Privacy Practices, which provides a detailed description of how the practice may use and disclose my protected health information, as well as other rights I have regarding my health information.

_____ **Initial**

_____ _____

Patient/Responsible Party Signature Date

_____

Patient/Responsible Party Printed Name