New Patient Registration

Patient Name: _____ Birth Date: _____

Social Security #: _____ ☐ Male ☐ Female

Cell Phone #: _____ Alt. Phone #: _____ Email: _____

Mailing Address: _____ City/State/Zip: _____

Primary Care Provider: _____ Pharmacy/Location: _____

Reason for Visit: _____

_____

Emergency Contact/Responsible Party

Name: _____ Relationship: _____

Cell Phone #: _____ Work Phone #: _____ Email: _____

Patient Demographics

☐ *I do not wish to share this information*

Race: _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Preferred Language: _____ ☐ Translation Needed

Credit Card/Debit Card Authorization

Acton Urgent Care submits claims to insurance carriers as a convenience to all our patients. At this time we request authorization to balance bill a major credit card or debit card to cover amounts determined by your insurance to be your responsibility.

Upon receipt of an explanation of benefits from your insurance any unpaid portion of your claim will be billed to your credit card/debit card upto $250. Should insurance pay in full, your account will not be charged. All credit card/debit card information will remain absolutely confidential and securely stored by **First Data**. Acton Urgent Care will not store any banking account data.

I hereby authorize Acton Urgent Care **to charge any and all outstanding balances, after insurance company reimbursement or denial, to my credit/debit card. I understand that I will not receive a statement if there is no balance due after processing my credit card for payment.**

Print Cardholder Name: _____

Signature of Cardholder: _____ SIGN HERE Date: _____

How did you hear of Acton Urgent Care?

☐ Drs. Office ☐ Sign Board ☐ Google Search ☐ Facebook

☐ Mailers ☐ Returning Patient ☐ Other _____

Dear Patient,

Acton Urgent Care is committed to maintaining the integrity of your protected health information and complies with all applicable state and federal regulations.

The federal privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA) have taken effect April 14, 2003. In support of our policy of complying with all applicable regulations, Acton Urgent Care provides patients with the HIPAA Notice of Privacy Rights.

While not required in order to receive treatment at Acton Urgent Care, we are obligated under federal regulations to ask that you sign an acknowledgement of the HIPAA Privacy Notice being made available to you.

Thank you.

Receipt of HIPAA Privacy Notice

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how Acton Urgent Care may use and disclose my protected health information. I understand that Acton Urgent Care reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

_____

Printed Patient Name

Sign Here

_____ Date: _____

Signature of Patient or Parent/Guardian

Office Use Only: To be completed only when a patient declines to sign acknowledgement.

Check here if patient declined to sign acknowledgement

Staff Signature: _____ Date: _____

Refusal to sign acknowledgement does not prevent the patient from continuing to be treated.

To be filed in patient's record

ACTON URGENT CARE

Thank you for choosing Acton Urgent Care for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read, make appropriate selection and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
PLEASE CHECK ONE BELOW:

☐ Check here if you agree to self-pay for services rendered, at time of service.

☐ Check here if you elect to use available medical insurance for visit coverage.
Self-pay rates <u>will not</u> apply after date of service.

- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of co-pays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Copays are due at the time of service.
- Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.
- Patients may incur, and are responsible for payment of additional charges, if applicable.

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to pursue the claim for workers' compensation or (2) it is determined the Workers' Compensation Board that the illness or condition which required treatment was not a result of compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law § 32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/services performed after the date the agreement is approved. if any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

You expressly consent and agree that, in order to discuss or service your accounts(s) (the "Accounts ") or to collect amounts you may owe, Acton Urgent Care, and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively, "We") may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contact you by sending text messages, emails, using any e-mail address you provide to us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

By my signature below, I hereby authorize assignment of financial benefits directly to Acton Urgent Care and associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Patient Name: _____

Patient/Guardian Signature: _____ Sign Here

Date: _____

Patient Consent Form

(Please Read and Sign)

ACTON URGENT CARE

I, the undersigned, hereby consent to the following treatment:

- Administration and performance of all treatments.
- Administration of any needed anesthetics.
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient.
- Use of prescribed medication.
- Performance of diagnostic procedures, tests, and/or cultures.
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designee.

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that Acton Urgent Care may include consent at satellite offices under common ownership.

You expressly consent and agree that, in order to discuss or service your account(s) (the "Accounts") or to collect amounts you may owe, Acton Urgent Care, and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively, "We") may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contact you by sending text messages, emails, or using any email address you provide us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

A photocopy of this consent shall be considered as valid as the original.

Medicare Patients: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Acton Urgent Care.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Sign Here

Patient (or Responsible Party) Signature	Date
Patient Name (Print)	Date of Birth