Patient Registration Form

Fields identified with an (*) must be completed.



Today's Date:							
	PATI	ENT INFORM	ATION				
Patient Name (First, Middle, Last)*:				Date	of Birth*:		
SSN:	Gender: 🗆 Mal	e 🗆 Female	Marital Status:	☐ Single	□ Married	☐ Divorced	□ Widowe
Mailing Address*:					Apt.	#:	
City*:			State*:		_ Zip Code	e*:	
Contact Numbers: Main*:	M	obile:		W	Vork:		
☐ I give my permission to have messages							
Please provide your email address:					S	o we can sen	d you receipt
and healthcare information. Your email ac	ldress will not be provi	ded to a third	party.				
Emergency Contact*:			Emerge	ncy Contact	t Phone*:		
		PCP					
Primary Care/Provider (PCP) Name:			Practice	Name:			
PCP Phone:							
	E	THNICITY/R/	ACE				
☐ African-American ☐ American Indian				□ Pacific	Islander/Ha	waiian	
□ Decline Response Preferred Languag			•				
- Decime Response Treferred Edinguay							
Charles II that and by Coding Coding			OUT FASTMED?		□ O+l :: A	ali i a siki a i a si	
Check all that apply. □ Online □ Drive	By Friend/Family	⊔ Event ∟	Flyer \square Medic	ai Provider	□ Other A	avertising	
		ANCE INFOR					
Please provide appropriate insurance cove		sure appropr	iate claims proce	ssing or ider	ntify your vis	sit as self-pay	if you are no
currently covered by a health insurance p							
Primary Insurance:							f Pay
☐ The patient is also the Insurance Subs			to the Responsib	le Party sec	tion.		
If the Insurance Subscriber is not the patie							
Insurance Subscriber's Name (First, Midd							
Date of Birth: S	SSN:	Emp	oloyer:				
	RES	SPONSIBLE P	ARTY				
$\ \square$ Financially responsible individual is th	e same as the Insuranc	e Subscriber	identified above	٠.			
Complete for minor patients or when pati	ent is not financially re	sponsible for	the account.				
Name of Person Responsible for this Acco	ount:				Relation	n:	
Date of Birth:	SSN:			Phone:			
Mailing Address:	Ci	ty:			State: _	Zip: _	
	WORKERS' COMPEN	NSATION ("V	/C") AUTHORIZ	ATION			
Employer Name:					Phone:		
Address:							
WC Carrier:							
Address:						Zip: _	
Date of Injury:							
I clearly understand and agree that all ser		-		n the event	that worker	s' compensa	tion benefits
are denied.		20 0110190			and worker	_ 00periou	
Patient Signature:					Date:		
For Office Use Only							
Employer Contact Providing Authorizatio	n to Treat [.]						
FastMed Employee Verifying Injury:							
Drug Screen Required: ☐ Yes ☐ No							

FINANCIAL POLICIES

At the time of service, FastMed collects from you the estimated amount of patient responsibility based on your specific insurance plan, our insurance contracts, and the eligibility information provided by your insurance company. Following your visit, you will receive an explanation of benefits from your insurance company stating the amount paid by your insurer and the remaining balance owed by you, if any. Patients are financially responsible for all services rendered that are not paid for by their insurance(s). All medical services are billed by FastMed and I authorize payment for insurance benefits, which may otherwise be payable to me, directly to FastMed. I authorize the release of information concerning my (or my dependent's) healthcare, advisement, and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I understand that I will be billed directly by and agree to pay FastMed for any outstanding balances should my credit/debit card be declined or canceled. I understand that a \$10 late fee will be applied to any unpaid balance I owe that is not paid within 30 days. I understand that my account will enter collections after 60 days of non-payment. I agree to reimburse FastMed the actual fees of any collection agency, which may be based on a percentage at a maximum of 40% of the unpaid balance, and all costs and expenses, including reasonable attorneys' fees incurred in such collection efforts. If my account is sent to collections, such fees may be assessed by the collection agency on behalf of FastMed. I also understand that I may be responsible for my balance due to any chargeback, reversal, or dispute as a result of my credit card company's or bank's refusal to remit payment to FastMed.

Patient/Representative Printed Name:

PAYMENT AUTHORIZATION

As a courtesy to our patients, FastMed keeps a credit/debit card authorization on file for each patient visit and will charge the card for any balance not paid by your insurance for that visit only. FastMed will also refund the card on file automatically if there are any amounts owed to you for that visit. The credit/debit card used for the visit will be the credit card on file unless you request a different credit/debit card be kept on file. You will receive an email with the notice for any charge or refund if you have provided us your email address. If the visit has a \$0 balance, then there will be no further charge or refund. If the visit is being billed under a government insurance plan, the credit card on file policy does not apply.

I authorize FastMed to charge my credit/debit card up to \$200 for any outstanding patient responsibility balance that remains after insurance

reimbursements have been applied for authorized medical services received at Fast credit/debit card if there is a balance due to me.	Med. I also authorize FastMed to Issue a re	rund to the same
Cardholder/Representative Authorizing Signature:	C)ate:
Cardholder/Representative Printed Name:	Email Address for Notice:	
ACKNOWLEDGMENT OF NOTICE OF PRI	VACY PRACTICES*	
I have read and had questions addressed concerning FastMed Urgent Care's Notice	of Privacy Practices.	
Patient/Patient Representative Signature:)ate:
For Office Use Only		
A good faith effort was made in attempting to obtain written acknowledgment of rec Acknowledgment could not be secured for the following reason(s):	eipt of the FastMed Urgent Care Notice of	Privacy Practices.
$\hfill\square$ Patient/representative refused to sign. Date of refusal:		
$\hfill\square$ Communication barriers prohibited us from obtaining an acknowledgment		
$\hfill\square$ An emergency situation prevented us from obtaining an acknowledgment		
□ Other. Please explain:		
Staff Signature:	[Date:
ACKNOWLEDGMENT OF PATIENT CHOICE AND PATIENT RIG	HTS AND RESPONSIBILITIES POLICY	:

In connection with your treatment at FastMed Urgent Care, your FastMed Urgent Care healthcare provider may recommend certain ancillary services as part of your overall care. FastMed Urgent Care offers certain ancillary services that patients may require such as X-rays, limited lab services, and certain pharmaceuticals. FastMed has arranged for limited durable equipment (DME) to be available on site for patient convenience through a third-party vendor. While FastMed Urgent Care makes these services available, we want you to know that if your FastMed Urgent Care healthcare provider prescribes any of these services for you, you are free to choose any provider or supplier you wish and are not required to obtain these services through or at FastMed Urgent Care. FastMed Urgent Care will offer local providers of such items and services to you upon your request.

I have been given the opportunity to review the forgoing regarding FastMed Urgent Care's Patient Choice Policy and have had any questions answered about the same addressed. By signing below, I acknowledge my understanding of this policy and my rights thereunder.

I have been provided FastMed's Patient Rights and Responsibilities Policy for review. I have had any necessary questions answered.

Patient/Patient Representative Signature: _

CONSENT FOR MEDICAL TREATMENT*

I, the patient or authorized patient representative, consent to any medical examination, evaluation, and treatment regarding any illness, injury, and/or health concern affecting me at any time I present to FastMed Urgent Care for medical treatment. These services may include, but are not limited to, laboratory procedures, X-ray examinations, and medical and/or surgical treatment procedures.

Patient/Patient Representative Signature: Date:

FOR MINOR PATIENTS

I, the undersigned, attest that I am the custodial parent or legal guardian of the above-referenced minor and hereby authorize FastMed Urgent Care to administer treatment, as it so deems necessary, to the minor. In the event that the minor has received treatment at the practice before the date of this consent form, I authorize such treatment in addition to the treatment mentioned above. In no event shall my signature to any such document have any effect on this consent form.

Name of Custodial/Legal Guardian:	Relationship to Minor:	
Other Individual Authorized to Consent for Treatment for Minor Child*	Date of Birth:	
Custodial/Legal Guardian Signature:	Date:	

*Consent to allow named individual to consent for minor treatment will remain in effect until written notice is provided revoking consent.

Version May 2017