Registration form

NOTE: You may download, print, and bring completed forms to our office OR use your browser to fill in your information. If you use your browser, make sure you save the form (Edge) or print to pdf (Chrome) prior to closing your browser window. This will save the form to your computer. Then you may print, or email the completed form along with a copy of your insurance card and ID to FrontDesk@BraseltonUrgentCare.com. **Please include your first and last name in the subject line of your email.**

Last Name: _______________________ First:______ __________________ DOB: / / M F (select one)

Street Address:___________________________________ City:______________________ State:________ ZIP:_____________

Social Security Number: ______________ Home Phone: _______________________Cell Phone: ________________________

Occupation: _______________________ Employer: _______________________ Employer Phone: _______________________

Due to HIPAA regulations, we are required to have the name of the person we are authorized to discuss your healthcare issues, in the event of a critical matter or emergency. (For patients over 18)

Agree

Disagree

____

Authorized Name Phone Number Relationship

INSURANCE INFORMATION

Primary insurance carrier:____

Subscriber's Name:_______________________________ DOB: ________/________/__________

Policy #:_____________________________________ Group #:____

Relationship to Patient	Subscriber SSN (required for Tricare)	Guarantor (responsible for bill)	Gender
			M: F:

Secondary insurance carrier (if applicable):

Subscriber's Name: __________________________________ Policy#: __________________ Group: ___________

Patient's relationship to subscriber: ____

Policyholder:	DOB: / /	Address (if different)	Home Phone:
Is this person a patient here?	Yes No	Is this visit due to workers' comp?	Yes No

IN CASE OF EMERGENCY

Name of local friend or relative, not living at the same address: ______________________________________

Relationship to patient: ________________ Home#: ____________________ Work#: ____________________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Braselton Urgent Care or insurance company to release any information required to process my claims.

Parent/Guardian Signature: ____ Date: / /

Pharmacy Name: __________________________ Address: ____

Patient Health History

Patient Name: ___________________________ DOB: ___/___/_______ Date:

Please list all medications you are currently taking including over-the-counter meds.

Medication	Dosage	Reason

Please Indicate any drug allergies: Reason for visit:

Please indicate any health conditions for which you are currently being treated or have ever been treated.

YES	**NO**	**Condition**	**YES**	**NO**	**Condition**
		Asthma			High Blood Pressure
		Arthritis			High Cholesterol
		Bleeding Disorder			Kidney Disease
		Cancer			Migraine
		COPD			Musculoskeletal
		Diabetes			Seizures
		Depression/Anxiety			Sickle Cell Disease
		Gastrointestinal			Sleep Disorder
		Heart Disease/Attack			Stroke
		Hepatitis			Thyroid Disease

Please list any surgeries, hospitalization and/or serious injuries.

Reason/Type	Date	Reason/Type	Date

Any chance you are pregnant? Yes No

Are you a smoker? Yes No If yes, how many packs a day?

Do you drink alcohol? Daily Socially Never

Patient Authorization

Patient Name: ________________________________ DOB: _______/_______/_______

Consent to Treat

I hereby authorize Braselton Urgent Care to render medical care to me during my office visit and to fulfill the orders of my physicians; including consultants, associates and assistants of the physician's choice.

Financial Authorization

I am financially responsible for the services provided which are to be paid on the day services are rendered. I further acknowledge that I am the owner/dependent of the insurance policy and that the insurance contract is between myself/policyholder and the insurance carrier. Braselton Urgent Care has no leverage to obtain payment from my insurance carrier. As such, Braselton Urgent Care will appropriately bill my insurance carrier however I will be responsible for all unpaid services due to copay, deductibles, or rejected claims.

Braselton Urgent Care will attempt to verify insurance coverage at the time of service. Benefit and eligibility information obtained may be inaccurate or incomplete and only the final Explanation of Benefits (EOB) sent from the insurance carrier will stand as the final statement of monies owed. I will be billed (or credited) for any outstanding balances (or overcharges) whereupon I am obliged to make payment within 30 days. After 60, past due amounts may be charged to my credit card kept on file with Braselton Urgent Care. I realize that failure to keep this account current may result in Braselton Urgent Care being unable to provide continuing medical services.

Consent to Use and Release of Medical Information

I authorize Braselton Urgent Care to release medical information pertaining to my diagnosis and/or treatment, laboratory results, medical history, treatment, or any other such related information to:

- My insurance company(ies) or its designated representatives.
- Any person(s) or entities financially responsible for my care or treatment.
- Representatives or local, state, or feral agencies in accordance with law.
- Employees or representatives for investigation and defense of any claim or cause of action, actual or potential which may be asserted against Braselton Urgent Care or its employees.

I have been provided with a **Notice of Privacy Practices** that provides a more complete description or information uses disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail copy of the revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree with the restrictions requested. I understand I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

____________________________________ ___________________________ ______/_____/_____

Signature of patient/Legal Representative Patient Name (printed) Date

Patient Consent for Disclosure of

Protected Health Information

I have the right to review the Notice of Privacy Practices prior to signing this consent. Braselton Urgent Care reserves the right to revise its Notice of Privacy Practices at any time.

I acknowledge and agree that Braselton Urgent Care and/or vendor including billing and/or collection companies may contact me on the numbers listed below. I further agree that I may be contacted by use of an Automated Telephone Dialing System (ATDS) or prerecorded message. With this consent, Braselton Urgent Care may share my Personal health information (PHI) in the following methods:

YES / NO

Leave a message on home phone? ____________________________

Home Phone

Leave a message on cell phone? ____________________________

Cell Phone

Send an email? ____________________________

Email Address

I authorize Braselton Urgent Care to release/disclose my PHI including lab and test results, diagnosis and treatments to the following individuals:

Name	Relationship	Phone Number
________________________	________________________	________________________
________________________	________________________	________________________

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent

____ ________________________

Signature of Patient or Legal Guardian Date

____

Print Patient's Name

____

NOTE: Thank you for completing your registration. Once you've submitted your forms, ID and insurance cards, we will call you about 15 minutes before it's your turn to be seen. Please wear a mask when you visit our clinic for any reason, to protect yourself and others. **If you have symptoms, please CALL first or schedule a Telemedicine visit.**

Once in the office, you will be taken back to a room, triaged, and tested. We will discuss treatment if you are symptomatic or have any other health concerns.

Results are currently taking up to 5 days to come in due to high volume. There is no need to call for your results as we will contact you when the results are available.