



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:

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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

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



Thank you for completing your registration. What's next?

Once you've submitted your paperwork, we will contact you approximately 45 minutes before we are ready to administer your test. After testing:

1. Please **DO NOT** call the office for results.
2. Our team is working diligently to call patients with their results. We request you to please wait patiently until our office contacts you.
3. It can take up to 5 days to get back results. However, if your results are not back within 3 days, and you need to reach us, please email TestResults@BraseltonUrgentCare.com.