



Bringing ER expertise to life's little emergencies
 2040 Boston Road, Wilbraham MA 01095
 Phone 413-599-3800 – Fax 413-279-1900



EXISTING PATIENT REGISTRATION FORM



PATIENT INFORMATION [Please print NEATLY & LEGIBLY]

FIRST	LAST	DOB / /
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YOUR REASON FOR BEING SEEN TODAY (In only a few brief words please)

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PHARMACY: If a prescription is needed today, which pharmacy do you want us to electronically send it to?

Name:	Location: (Street & City)
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AUTHORIZATION FOR TREATMENT

- I hereby authorize medical treatment by the provider, the clinical staff and technical employees assigned to my care.
- I authorize my treating providers to order any ancillary services deemed necessary for my care and treatment.
- I understand that I have the right and the opportunity to discuss alternative plans of treatment with the provider or other healthcare provider and to ask and have answered to my satisfaction any questions or concerns.
- I understand that Urgent Care of Wilbraham utilizes an electronic medical record system. I understand that this system is maintained in accordance with HIPAA and other patient privacy and health information management regulations. I understand that the providers and appropriate staff will have access to my healthcare information across the continuum of my care.
- I understand that Urgent Care of Wilbraham utilizes an electronic prescribing mechanism for electronic transmission of prescriptions to my local pharmacy of choice.
- I consent to the release of my prescription history from any pharmacy or drug monitoring agency to the provider/practice.
- In the event that a healthcare worker is exposed to my blood or body fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus, or hepatitis C virus, I consent to the testing of my blood and/or body fluids for these infections and the reporting of my test results to the health care worker who has been exposed, as required by Massachusetts law.

PAYMENT FOR SERVICES & PATIENT RESPONSIBILITIES

- I agree to be responsible for payment of all services rendered, to me and/or my dependents.
- I authorize the assignment to Urgent Care Specialists, PC d/b/a Urgent Care of Wilbraham of all payments under any insurance benefits otherwise payable to me for services provided under any insurance policy (medical, workers' compensation, motor vehicle personal injury, or any other insurance or benefit plan).
- I authorize the release of my Protected Health Information (PHI) to my insurance companies or other third party payers, including their representatives, as necessary to determine coverage or as required for review, quality improvement, and/or management.
- I agree to pay, at the time of service, any required co-payments.
- I agree to pay any co-insurances or deductibles, as well as charges for services not covered by my insurance, including those deemed NOT a medical necessity for treatment, either at the time of service or later determined by an insurance provider.
- I understand that all unpaid balances will be billed to my address on file with this office and that I am responsible for updating my information as necessary.
- I understand that I am responsible for paying the balance of my bill in full unless other arrangements have been approved in advance.
- I understand that there is a \$25 fee charged for returned checks and any future payment must be made by alternate methods.
- I understand that past due accounts will be referred to a collection agency and that I will be responsible for all collection charges, associated legal fees, and the full balance on my account.

By signing this document, I agree that *I have read, understand and agree to the above terms*, and that reproductions are as legally binding as the original.

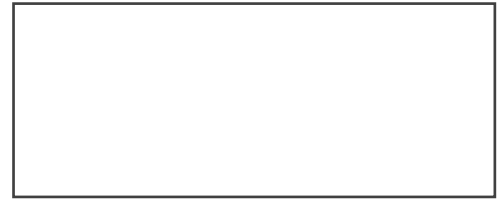
X _____	_____	_____
PATIENT Signature	Guarantor Signature	Relationship



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**EXISTING PATIENT
 DEMO UPDATE FORM**



**Please print NEATLY & LEGIBLY any changes necessary.
 If there are no changes needed, you may skip those boxes.**

PATIENT INFORMATION			
FIRST	MI	LAST	Suffix (Sr, Jr, III, IV etc)
DOB / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Preferred First Name (if different)
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other or Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W
Birthplace:	Employer:	Occupation:	

Primary Phone <input type="checkbox"/> Cellphone () - <input type="checkbox"/> Leave Messages?	Secondary Phone <input type="checkbox"/> Cellphone () - <input type="checkbox"/> Leave Messages?
Home Address:	City: State: Zip Code:
Mailing Address: (if different from above)	City: State: Zip Code:

Person to Notify in Case of Emergency:	Relationship:
Primary Phone <input type="checkbox"/> Cellphone () - <input type="checkbox"/> Leave Messages?	Secondary Phone <input type="checkbox"/> Cellphone () - <input type="checkbox"/> Leave Messages?
Address: <input type="checkbox"/> Same as above	City: State: Zip Code:

Your Primary Care Physician's (PCPs) Name:	Office Location:
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GUARANTOR* / INSURANCE SUBSCRIBER INFORMATION [If you are the subscriber, leave this section blank]			
<small>*The guarantor is the adult who is responsible for a minor or dependent and authorizes services and treatment today.</small>			
FIRST	MI	LAST	Suffix (Sr, Jr, III, IV etc)
DOB / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Relationship to patient