URGENT CARE of Wilbraham

2040 Boston Rd, Wilbraham MA 01095
Phone 413-599-3800 – Fax 413-279-1900

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION [*Please print NEATLY & LEGIBLY*]

FIRST	MI	LAST	Suffix (Sr, Jr, III, IV etc)

DOB / /	Gender ☐ Male ☐ Female	*Preferred* First Name *(if different)*

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other or Unknown	Ethnicity ☐ Hispanic or Latino ☐ *Not* Hispanic or Latino	Marital Status ☐ S ☐ M ☐ D ☐ W

Birthplace:	Employer (or School if Student):	Occupation:

Primary Phone ☐ Cellphone ☐ Leave Messages? ( ) -	Secondary Phone ☐ Cellphone ☐ Leave Messages? ( ) -

Home Address:	City:	State:	Zip Code:

Mailing Address: (if different from above)	City:	State:	Zip Code:

PRIMARY INSURANCE SUBSCRIBER INFORMATION ☐ *Same as patient. If not, complete section below*

FIRST	LAST & Suffix (Sr, Jr, III, IV etc)	DOB / /	Relation to patient ☐ Spouse ☐ Parent ☐ Other:

Your Primary Care Provider (PCPs) Name:	Office Location:

Name of Person to Notify in Case of Emergency:		Relationship:

Primary Phone ☐ Cellphone ( ) -	Secondary Phone ☐ Cellphone ( ) -

Address: ☐ *Same as above*	City:	State:	Zip Code:

YOUR REASON FOR BEING SEEN TODAY *(In only a few brief words)*

	Is this related to a(n): ☐ Assault ☐ Motor Vehicle Accident ☐ Workplace injury

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

Store Name:	Location: (Street & City)

Office Use: ___ Ins. Verified ____ AllScripts ___ XPM Entered ____XPM Scanned PSR Initials: _____

SIGN CONSENT

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NEW PATIENT CONSENT FORM

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.
- I authorize the release of my Protected Health Information (PHI) to my primary care provider (PCP) listed for continuum of care.
- 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.

PRIVACY PRACTICES & DISCLOSURES

Our Notice of Privacy Practices (NPP) provides information about how we may use and disclose your personal health information. By signing below, you acknowledge that you may access our NPP on our website. A paper copy may be furnished upon request at no cost to you.

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 **Date**

Revised: 2015-11-11