CAROLINA URGENT AND FAMILY CARE

REGISTRATION FORM

Insurance _____ Self Pay _____ Workers Comp _____ Motor Vehicle Accident _____

Reason for visit:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Address:	Cell phone no: ( )	Home phone no.: ( )

Social Security no:	City:	State:	ZIP Code:

Email:	Employer:	Employer phone no.: ( )

Would you like to know more about how to become a primary patient? ❑ Yes ❑ No

INSURANCE INFORMATION

If you are the subscriber and have your insurance cards skip to the next section

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No Name of primary insurance:

Subscriber's name:	Subscriber's S.S. no:	Birth date: / /

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

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 Carolina Urgent and Family Care or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

CONSENT FOR TREATMENT

The undersigned patient and/or responsible relative or person hereby consent to authorize Carolina Urgent and Family care physicians and medical personnel to administer and perform medical examinations, investigations, medical treatments, outpatient procedures during the course of patient's care as an outpatient be deemed advisable or necessary. The undersigned also consents to the office contacting him/her by telephone if needed regarding appointments and follow-up needs.

Patient/Guardian signature *Date*

MEDICATION HISTORY CONSENT FORM

By signing below I give permission to Carolina Urgent and Family Care to access my pharmacy benefits data electronically through RxHub. This consent will enable Carolina Urgent and Family Care to:

- Determine the pharmacy benefits and drug co pays for the patients health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

____________________________________ ____________________________________
Patient Name (Print) Pharmacy

____________________________________ ____________________________________
Patient Signature Date

AUTHORIZATION FOR RELEASE OF INFORMATION

Carolina Urgent and Family Care is authorized to release protected health information about the above named patient to the entities below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information
Check each person/entity that you approve to receive information

_____ Voice Mail

_____Spouse

_____Parent (provide name) ____________________

_____Other (provide name) ____________________

Description of information to be released
Check each that can be given to the person/entity listed above

_____ Results of lab test/x-rays

_____ Appointment information

_____Billing information

_____ All information

If you would like to gain access to your medical record online, please let the receptionist know at check-in.

I hereby acknowledge that on this date, I received a copy of the HIPPA Notice of Privacy Practices as published by Carolina Urgent and Family Care. I have read and understand the Insurance Billing Policy for Carolina Urgent and Family Care and I agree to be bound by its terms. I also understand that Carolina Urgent and Family Care may modify these terms at any time without notice. Once signed by you this policy will remain in effect as long as you are a patient of Carolina Urgent and Family Care.
All patients should understand that any patient seeking medical treatment is not considered a patient of the practice until **our Provider** has completed a review of the patient's **Medical History** and **an In-Person** assessment of that patient **in our office**.

Signature:____ Date:__________________________