Patient Registration Form

Fields identified with an (*) must be completed.

Gateway Urgent Care

Today's Date:_____

Patient Information

Patient Name (First, Middle, Last)*_____ Date of Birth*:_____

SSN:_____ Gender: Female Male Marital Status: Single Married Divorced Widowed

Mailing Address:*_____ Apt #:_____

City*:_____ State*:_____ Zip Code*:_____

Email: (required to use online payment system and patient portal):_____

May we send you information via email? Your email will not be provided to a third party. Yes No

Contact Numbers*: Home_____ Cell:_____ Work:_____

Preferred Method of Appointment Reminders (select one): Phone Email Text

How did you hear about us: Friend /Family Online Search Radio Social Media Special Event Television Other

Emergency Contact_____ Emergency Contact Phone_____

Preferred Pharmacy

Preferred Pharmacy Name:_____ Preferred Pharmacy Phone:_____

Preferred Pharmacy Address or Cross Streets:_____

Ethnicity/Race

American Indian/Alaskan Native Asian Black/African American Native Hawaiian/Pacific Islander White/ Caucasian

Preferred Language: □ English □ Other_____

Responsible Party/Insurance Information

Responsible Party Name (First, Middle, Last)*:_____

Relation*:_____ Date of Birth*:_____ SSN:_____-_____-_____

Phone:* _____ Employer_____

Mailing Address:*_____ Apt #_____

City*:_____ State*:_____ Zip Code*:_____

Primary Insurance_____ Secondary Insurance _____

FINANCIAL POLICIES

At the time of service Gateway Urgent Care (GUC) collects from you the estimated amount of patient responsibility based on your specific insurance plan, our insurance contracts, and the eligibility information provided by your insurance company. While we do our best to verify your insurance coverage it is your responsibility to ensure that you have an insurance policy in force with benefits that will cover our services. We make no guarantee that your policy will cover any of our services or outside services such as specialists, laboratory or radiology. Following your visit, you will receive an explanation of benefits (EOB) from your insurance company stating the amount paid by your Insurer and the remaining balance owed by you, if any. Patients are financially responsible for all services rendered that are not paid for by their insurance(s). All medical services are billed by GUC and I authorize payment for Insurance benefits, which may otherwise be payable to me, directly to GUC. I authorize the release of Information concerning my (or my dependent's) healthcare, advisement, and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I understand that I will be billed directly by and agree to pay GUC for any outstanding balances should my credit/debit card be declined or canceled. I understand that a $10 late fee will be applied to any unpaid balance I owe that is not paid within 30 days. I understand that my account will enter collections after 60 days of non-payment. I agree to reimburse GUC the actual fees of any collection agency, which may be based on a percentage at a maximum of 40% of the unpaid balance, and all costs and expenses, inducing reasonable attorneys' fees Incurred in such collection efforts. If my account is sent to collections, such fees may be assessed by the collection agency on behalf of GUC. I also understand that I may be responsible for my balance due to any charge back, reversal or dispute as a result of my credit card company's or bank's refusal to remit payment to GUC.

Patient/Authorized Representative Signature_____ Date_____

Patient/Authorized Representative Printed Name _____

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I have read and had questions addressed concerning Notice of Privacy Practices.

Patient/Authorized Representative Signature_____ Date_____

FOR MINOR PATIENTS

I, the undersigned, attest that I am the custodial parent or legal guardian of the above-referenced minor and hereby authorize GUC to administer treatment, as it so deems necessary, to the minor. In the event that the minor has received treatment at the practice before the date of this consent form, I authorize such treatment in addition to the treatment mentioned above and to all future care until this authorization is revoked in writing. In no event shall my signature to any such document have any effect on this consent form.

Guardian Signature_____ Date_____

Guardian Printed Name _____ Relationship_____

ACKNOWLEDGMENT OF PATIENT CHOICE POLICY

In connection with your care, your GUC provider may recommend certain ancillary services as part of your overall care. GUC offers certain ancillary services that patients may require such as x-ray, limited lab services, and certain pharmaceuticals. While GUC makes these services available, we want you to know that if your GUC provider prescribes any of these services for you, you are free to choose any provider or supplier you wish and are not required to obtain these services through or at GUC. GUC will offer local providers of such Items and services to you upon your request.

I have been given the opportunity to review the forgoing regarding GUC's Patient Choice Policy and have had any questions answered about the same addressed. By signing below, I acknowledge my understanding of this policy and my rights there under.

Patient/Authorized Representative Signature_____ Date_____

CONSENT FOR MEDICAL TREATMENT

I. the patient or authorized patient representative, consent to any medical examination, evaluation, and treatment regarding any illness, injury, and/or health concern affecting me at any time I present to GUC for medical treatment. These services may include, but are not limited to, laboratory procedures, and medical and/or surgical treatment procedures.

Patient/Authorized Representative Signature_____ Date_____