Lanier
URGENT CARE

REGISTRATION FORM

PATIENT INFORMATION

Last Name: First:	DOB:	M / F : (circle one)
Street Address: City: State: Zip:		
Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

Pharmacy Name & Address:

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:	Birth date:	Policy #:	Group #:	Co-payment:

Patient's relationship to subscriber:

Is the patient under 18? ○ Yes ○ No	Relationship to Patient (if under 18)	Guarantor (responsible for bill :)	Patient Birth date:	Age:	Sex: ○ M ○ F

SECONDARY insurance carrier (if applicable):	Subscriber's name:	Policy#:	Group#:

Patient's relationship to subscriber:

Policyholder:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?	○ Yes ○ No	Is this visit due to workers compensation?	○ Yes ○ No

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 to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Gwinnett Urgent Care or insurance company to release any information required to process my claims.

Patient/Guardian signature **Date**

PATIENT HEALTH HISTORY

Patient Name: _____ DOB: _____ Date: _____

Please list all medications you are currently taking including any over-the-counter meds.

Medication	Dosage	Reason

Please indicate any drug allergies.

Reason for Visit:

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/Heart 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: _____ **Date of Birth** ___/___/___

Consent to Treat

I hereby authorize Lanier Urgent Care, PC 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. Lanier Urgent Care has no leverage to obtain payment from my insurance carrier. As such, Lanier Urgent Care will appropriately bill my insurance carrier however I will be responsible for all unpaid services due to copays, deductibles, or rejected claims.

Lanier 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 days, past due amounts may be charged to my credit card kept on file with Lanier Urgent Care. I realize that failure to keep this account current may result in Lanier Urgent Care being unable to provide continuing medical services.

Consent to the Use and Release of Medical Information

I authorize Lanier 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.
- Representative or local, state, or federal 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 Gwinnett Urgent Care or its employees.

I have been provided with a Notice of Privacy Practices that provides a more complete description or information uses and 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 a 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**

BACK

Patient Consent for Disclosure of Protected Health Information

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Lanier Urgent Care** reserves the right to revise its Notice of Privacy Practices at any time.

I acknowledge and agree that **Lanier Urgent Care** and/or vendors 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, **Lanier Urgent Care** may share my Personal Health Information (PHI) in the following methods:

Leave a message on your home phone? YES / NO _____
Home Phone Number

Leave a message on your cell phone? YES / NO _____
Cell Phone Number

Send an email? YES / NO _____
Email Address

I authorize **Lanier 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 Name:_____