Patient Registration Form

american family care URGENT CARE

Reason for Visit:_____

Patient Name (First, Middle, Last): _____

SSN:_____Sex at Birth: _____ Marital Status: _____ Date of Birth: _____

Primary Care/Provider Name:_____PCP Phone: _____

Mailing Address:_____Apt. # _____

City:_____State:_____Zip:_____

Confidential Email Address:_____

Contact #'s: Can we leave a message?

Cell:_____Yes No

Home: _____Yes No

Work: _____Yes No

Emergency Contact Name:_____

Emergency Contact Phone:_____

Based on Government Regulations, we are required to ask the following: ____ I prefer not to answer

Ethnicity:_____Preferred Language:_____Race:_____

How did you hear about AFC Urgent Care? __ Healthcare Referral __Employer Recommendation

__ Existing Patient __ Friend/Relative Recommendation __ Signage __ Internet __ TV/Radio

Primary Insurance Company Name:_____

Insurance Subscriber's Name (First, Middle, Last):_____Relation:_____

Date of Birth:_____SSN;_____Employer:_____

Secondary Insurance Company Name:_____

Insurance Subscriber's Name (First, Middle, Last):_____Relation:_____

Date of Birth:_____SSN;_____Employer:_____

Responsible Party— Complete for Minor Patient OR when Patient is NOT Financially Responsible for Account

Name of Person Responsible for this Account: (state "SELF" if same a patient)_____

Relation:_____Date of Birth:_____SSN:_____Phone:_____

Mailing Address:_____Apt:_____City:_____State:_____Zip:_____

Patient's Financial Responsibility/Consent for Treatment

You agree, in order for us to service your account or to collect any amounts you may owe us, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text message or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that AFC Urgent Care may contact me/us as described above. I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office is due at the time of service. I also understand that charges not covered by insurance remain my responsibility and assign insurance benefits to this office. I agree to pay all late fees, costs of collection fees, and/or attorney's fees and all court costs, if any.

Patient/Responsible Party Signature:_____Date:_____

I authorize this office to store my payment card and bank information into the Merchant Services Database. I authorize the payment card being presented today to be used by AFC Urgent Care to cover any current or prior unpaid balances, either private pay or following submission of claims to my insurance plan. Any unpaid balances will be charged to the payment card within one week of AFC Urgent Care receiving notice of my insurance company's denial of payment.

Patient/Responsible Party Signature:_____Date:_____

I, the undersigned, consent to the care and treatment by the attending physician, his/her associates or assistants. I acknowledge that no guarantees have been made as to the effect of such treatment. Additionally, if any health care professional, worker or employees should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infectious disease (s). A physician or other health care provider will tell you the result of the test. Under VA. Code 32.1-45.1(A), NC G.S 130A-139, you are deemed to have consented to the release of the test results to the person exposed.

Patient/ Responsible Party Signature:_____Date:_____

I have reviewed the AFC Urgent Care Notice of Privacy Practices on the back of this form and understand that I may request a copy of the policy at any time. **Patient/Responsible Party Signature:**_____**Date:**_____