



# PHYSICIANS CARE

An Affiliate of Urgent Team

## Patient Registration Form

### Patient Information

Name: \_\_\_\_\_  Male  Female

DOB: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

Personal Email: \_\_\_\_\_

Primary Care Physician (PCP): \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Best Form of Contact:  Mobile  Email  Mail \_\_\_\_\_


Best Time to Call: \_\_\_\_\_ May we leave a message?  Yes  No

### Race

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian/Other Pacific Islander
- White
- Declined to Specify
- Other

*In order for us to service your account or collect any amounts owed to us, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which may result in additional charges from your phone carrier. We may also contact you by sending an email using the email address you have provided.*

**By initialing, I acknowledge that I have read this disclosure and agree that you may contact me as described above.**

 \_\_\_\_\_  
PLEASE INITIAL

### Emergency Contact

*This person will be contacted in emergencies and allowed to receive information about your medical treatment.*

Name: \_\_\_\_\_  Male  Female

Relationship: \_\_\_\_\_ Mobile Phone \_\_\_\_\_

### Financial Responsibility

Check if same as patient information. If not, please complete the entire section.

Name: \_\_\_\_\_  Male  Female

Relationship: \_\_\_\_\_

DOB: \_\_\_\_\_

Phone: \_\_\_\_\_

### Insurance Information

Check if same as patient information. If not, please complete the entire section.

Primary Insurance: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Subscriber #: \_\_\_\_\_

Subscriber #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

### Consent for Treatment/Acknowledgement of Privacy Practices/Acknowledgement of Financial Responsibility

*I, the undersigned, consent to the care and treatment by the attending Physician, his/her associates or assistants and acknowledge that no guarantees have been made as to the effect of such treatment.*

*I have reviewed the Notice of Privacy Practices as provided at registration and understand that I may request a copy of the policy at any time.*

*I acknowledge full financial responsibility to any services received and I understand that the payment of charges incurred in this office is due at the time of service. I also understand that the charges not covered by insurance remain my responsibility. In the event that my account is turned over to a collection agency, I agree to pay all late fees, costs of collection fees and/or Attorney's fees and all court costs, if any. I understand that any services not provided directly by Physicians Care (Lab results, diagnostic services) are a separate charge and those charges will be billed separately by the provider of such services.*

\_\_\_\_\_  
Signature (Patient/Guardian)

\_\_\_\_\_  
Date:



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## Secure Pay Enrollment Form

By signing this form you give Physicians Care permission to charge your Credit/Debit/HSA card indicated below up to \$300 for any amount not paid by insurance. This authorization applies to each balance prior to or after the date of this authorization. Prior to charging your account, you will receive a statement notifying you of the amount due. Following the receipt of the statement, you will have 2 weeks from the statement date to contact Physicians Care if you would like to make alternative arrangements for payment. *Services to Include: Office visit and any related services including, but not limited to, Labs, x-rays, injections, any additional ancillaries, etc.*

**Please complete the information below:**

I \_\_\_\_\_ authorize \_\_\_\_\_ (Center Name)  
to keep my signature securely on file and to charge my Credit/Debit/HSA card indicated below  
up to \$300 for any amount not paid by insurance.

Account Type: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> AMEX <input type="checkbox"/> Discover	OFFICE USE ONLY:
Cardholder Name: _____	<input type="text"/>
Credit Card # (Last 4): _____	PATIENT ID:
Cardholder Address: _____ (If different than patient)	

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date:

I authorize the above named business to charge the Credit/Debit/HSA card indicated in this authorization form according to the terms outlined above. I certify that I am an authorized user of this credit card. This authorization expires one year after the above date.