PHYSICIANS CARE

An Affiliate of Urgent Team

PhyCare.net

Patient Registration Form

Patient Information

Name: _____ ☐ Male ☐ Female

DOB: _____

Mailing Address: _____ Apt #: _____

City, State, Zip: _____

Mobile Phone: _____

Personal Email: _____

Primay 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

DOB: _____

Relationship: _____

Phone: _____

Insurance Information

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

Primary Insurance: _____

Subscriber #: _____

Subscriber Name: _____

DOB: _____ Relationship: _____

Secondary Insurance: _____

Subscriber #: _____

Subscriber Name: _____

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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SecurePayEnrollmentForm

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 an email notification notifying you of the amount due. Following the receipt of the notification, you will have 7 business days 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: Visa MasterCard AMEX Discover

Cardholder Name: _____

Credit Card # (Last 4): _____

Cardholder Address:_____
(If different than patient)

OFFICE USE ONLY

Patient ID:_____

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.