



# 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.:	

**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
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**INSURANCE INFORMATION**

**PRIMARY** insurance carrier:

Subscriber's name:	Birth date:	Policy #:	Group #:
Patient's relationship to subscriber:			
Relationship to patient:	Subscriber SSN (required for TriCare):	Guarantor (responsible for bill :)	Gender: <input type="radio"/> M <input type="radio"/> F

SECONDARY insurance carrier (if applicable):	Subscriber's name:	Policy#:	Group#:
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Patient's relationship to subscriber:			
Policyholder:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?	<input type="radio"/> Yes <input type="radio"/> No	Is this visit due to workers' compensation?	<input type="radio"/> Yes <input type="radio"/> 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.:
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Lanier 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 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 Lanier 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 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



**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 vendor 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 home phone?                      YES / NO                      \_\_\_\_\_  
Home Phone Number

Leave a message on 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's Name