Tower Health Urgent Care
Advancing Health. Transforming Lives.

# Patient Registration Form

Information identified with * is required

Thank you for choosing Tower Health Urgent Care. Please complete all applicable fields below. This information will remain confidential.

| **Patient Information** | | | |
|---|---|---|---|
| ***Patient Full Name:** | | | Date: / / |
| ***Date of Birth:** / / | *SSN: - - | Gender: ☐M ☐F | Marital Status: ☐S ☐M ☐D ☐W |
| ***Address:** | | Do you have a Primary Care Physician (PCP)? ☐Yes ☐No | |
| ***City:** | ***State:** ***Zip:** | Did PCP refer you to TH Urgent Care? ☐Yes ☐No | |
| ***Main Phone:** | Cell Phone: | PCP Name: | |
| Email: | (used for health alerts, insurance carrier changes, service changes and marketing ) | PCP Address (City, State): | |
| Preferred Pharmacy: | | City: State: Zip: | |
| Emergency Contact: | | Emergency Contact Phone: | |
| How did you hear about THUC ? : ☐Healthcare Referral ☐Friend/Family ☐Print Ad ☐Mailer ☐ Event ☐ Radio ☐Online (google, etc.) | | | |

| **Insurance Information** | | |
|---|---|---|
| ***Subscriber Full Name:** | | ***Name of Insurance:** |
| ***Subscriber DOB:** / / | SSN: - - | Relation to Patient: ☐ Self ☐Child ☐Spouse ☐Other |
| Policy #: | Group #: | |
| Secondary Insurance Name: | Subscriber Name: | DOB: / / |
| Is today's visit due to an Auto Accident? ☐Yes ☐No | If yes, in which state did the accident occur? | Claim #: |

| **Responsible Party** ***(if patient is not financially responsible for account)*** | | |
|---|---|---|
| Responsible party full name: | DOB: / / | SSN: - - |
| Address: | | Relation to Patient: ☐ Self ☐Child ☐Spouse ☐Other |
| City: State: Zip: | | Phone: |

| **Worker's Compensation (WC) Information and Authorization** | | |
|---|---|---|
| *Employer Name: | Supervisor/HR Coordinator: | *Phone: |
| *Address: | *City: *State: * Zip: | |
| WC Carrier: | Phone: | Claim #: |
| Address: | City: State: Zip: | |
| *Date of Injury: / / | Did you report this injury to your employer? ☐Yes ☐No | |
| I understand and agree that I will be financially responsible for all WC charges in the event that my WC Benefits are denied. **Signature of Patient or Guarantor:** **Date:** | | |

Payment is required at the time that services are rendered unless you are a member of a participating insurance plan of THUC. I authorize the release of information concerning my(or my child's) healthcare, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. If THUC bills my health insurance company on my behalf, I authorize payment to be paid directly to THUC. Any applicable co-payment, co-insurance and/or deductible will be collected at time of service. I understand that THUC will make every effort to identify whether my insurance is participating with THUC and has contracted to perform services at a predetermined rate; however, I am ultimately responsible for understanding my insurance coverage and whether my insurance coverage is participating with THUC and contracted to perform services at a predetermined rate. I understand that my insurance company will make the final determination as to what services are covered. I understand the terms of payment and I have been given the opportunity to read THUC's Financial Policy. I understand and accept that I am ultimately responsible for payment of services rendered by THUC if such services are not paid for by my insurance(s). I understand that a late charge of 1.5% per month may be applied to any unpaid patient balance that is not paid within 30 days from receipt of a bill. I understand that a charge of $50 is applied for any returned personal checks due to insufficient funds. I authorize my information to be accessed by all THUC clinics to provide continuity of care. This information includes, but is not limited to: diagnoses, prescriptions, treatment plans, lab results, referrals, and x-ray reports.

**X**: _____ Date: _____

**Signature of Patient or Guarantor**

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## Acknowledgement of Notice of Privacy Policy

I have been provided understand that this acknowledgement is not required to receive treatment at Tower Health Urgent Care. I acknowledge, under federal guidelines of the HIPAA Privacy Notice, that I have been given the opportunity to thoroughly read and have had any questions answered about the Notice of Privacy Practices at Tower Health Urgent Care. I acknowledge receipt of the Notice of Privacy Rights with detailed information regarding how Tower Health Urgent Care may use and disclose my protected health information. I understand that Tower Health Urgent Care reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

☐ I **DO** give permission for Tower Health to leave a detailed message with my health information. **My Preferred Number**:_____

☐ I **DO NOT** give my permission for Tower Health to leave a detailed message with my health information.

**X**: _____ Date:_____

**Signature of Patient or Guarantor**

**FOR OFFICE USE ONLY:**

An effort has been made to obtain written acknowledgement of receipt of Tower Health Urgent Care's Notice of Privacy Practices. Acknowledgement could not be obtained for the following reason(s):

☐ Patient/Guardian refused to sign on this date: _____

☐ Communication/language barriers prohibited obtaining acknowledgement

☐ An emergency prohibited obtaining acknowledgement

☐ Other (explain)

Refusal to obtain acknowledgement does not prevent the patient from continuing to be treated at Tower Health Urgent Care.

Employee Signature**:** _____ Date:_____

## Acknowledgement of Patient Choice for Ancillary Services

Tower Health Urgent Care may recommend certain ancillary services as part of your overall healthcare. These services include advanced imaging, limited lab services and certain pharmaceuticals. Tower Health has contracted with a third party vendor of limited durable equipment so that this equipment is available to you at the time of treatment. As your healthcare provider, Tower Health Urgent Care will make these services available to you; however, it is ultimately your choice to accept or deny such services. You are not required to obtain these services through Tower Health Urgent Care. Should you accept such services, you may incur additional expenses due to services being managed by a third party vendor.

By signing this document, I, being the patient/legal guardian acknowledge my understanding of the above regarding Tower Health Urgent Care's Patient Choice policy and have had any questions addressed.

**X**: _____ Date:_____

**Signature of Patient/Guardian**

## Authorization to Treat

I understand that this authorization is voluntary and I may refuse to provide authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I may inspect or copy the information to be used or disclosed, and that information used or disclosed to my primary care physician may be subject to re-disclosure by the primary care physician, and may no longer be protected by federal and state privacy regulations. I further understand that I may revoke this authorization at any time by providing written notification to the Health Information Management Department at Tower Health. The revocation will not affect any actions taken before the receipt of the written revocation.

By signing this document, I, being the patient/legal guardian authorize Tower Health Urgent Care to provide medical care in accordance with currently accepted medical standards and guidelines.

**X**: _____ Date:_____

**Signature of Patient/Guardian**

## Consent to Treat a Minor *(if applicable)*

I confirm that I am the parent or legal guardian of the above-referenced minor. I hereby authorize Tower Health Urgent Care to provide medical care as it so deems necessary to the minor. In the event that the minor has received treatment at Tower Health Urgent Care prior to the date of this form, I hereby authorize treatment in addition to the treatment(s) of a prior date.

X: _____ Date:_____

**Signature of Patient/Guardian**