REGISTRATION FORM

PATIENT INFORMATION:

NAME ______________________________ DATE OF BIRTH ____/____/____ GENDER M F
(LAST) (FIRST) (M.I.)

ADDRESS ______________________________ PHONE # ______________
(CITY) (STATE) (ZIP)

SSN ______ / _____ / ______ DRUG ALLERGIES ______________________ MARITAL STATUS M S D W

EMERGENCY CONTACT ______________________________ DRIVER'S LIC # & STATE ____________
(NAME) (RELATIONSHIP) (PHONE)

RACE______________ ETHNICITY HISPANIC OR LATINO YES NO PRIMARY LANGUAGE ______________

EMAIL ADDRESS ______________________________

RESPONSIBLE FOR PAYMENT:

NAME ______________________________ DATE OF BIRTH ____/____/____
(LAST) (FIRST) (M.I.) (RELATIONSHIP)

ADDRESS ______________________________ PHONE # ______________
(CITY) (STATE) (ZIP)

SSN ______/_____/______ EMPLOYER ______________________ EMPLOYER PHONE # ______________

MSP QUESTIONNAIRE

MEDICARE NUMBER ____________ EMPLOYED? YES NO RETIREMENT DATE __________ DISABLED? YES NO

EMPLOYER NAME & ADDRESS ______________________________
(CITY) (STATE) (ZIP)

EMPLOYER GROUP HEALTH PLAN NAME & ADDRESS______________________________
(CITY) (STATE) (ZIP)

POLICY NUMBER ______________________ INSURED DATE OF BIRTH _____ / _____ /_____

SPOUSE'S NAME ______________________ **DATE OF BIRTH** _____ / _____ / _____ EMPLOYED? YES NO

RETIREMENT DATE ____________ POLICY NUMBER ______________________

EMPLOYER GROUP HEALTH PLAN NAME & ADDRESS______________________________
(CITY) (STATE) (ZIP)

PAYMENT POLICY

It is the policy of Immediate Care to request payment in full at the time of service. Acceptable payment includes ATM, cash, check, charge card, or money order. Current insurance coverage is acceptable, and as a courtesy, Immediate Care will bill the insurance company for reimbursement. All services provided in our facility are billed as a doctor's office, not urgent care. Some providers are considered specialists and may result in a higher copay as per your insurance contract. If payment of the account has not been made by either the patient or the insurance company within sixty (60) days, the patient is expected to pay the balance in full. Regardless of insurance coverage the patient is expected to pay (at time of service) any co-payments, unmet deductibles, charges for pharmaceuticals, and all charges not covered by the policy.

Quest Diagnostics and GI Pathology will be used for all outside laboratory services unless prior arrangements have been made.

Except for companies with which we have agreements, our office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. Regardless of any claim pending, if there is an open balance, a statement will be sent to you.

Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay accrual of attorney's fees and collection expenses. Your signature indicates that you are aware of Immediate Care's payment policy, and also gives permission to Immediate Care to bill insurance, release any information necessary for billing and receive payment directly from the same.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give consent for Immediate Care Medical Center to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). (The Notice of Privacy Practices provided by Immediate Care Medical Center describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Immediate Care Medical Center reserves the right to revise its Notice of Privacy at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Dr. Smith 376 Vallombrosa Avenue Chico, CA 95926.

With this consent, Immediate Care Medical Center may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Immediate Care Medical Center may mail to my home or other alternative location or email any items that assist the practice in carrying out TPO, such as appointment reminder cards, and patient statements as long as they are marked "Personal and Confidential".

By signing this form, I am consenting to allow Immediate Care Medical Center to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Immediate Care Medical Center may decline to provide treatment to me.

Signed by: ______________________ ______________ ______________
Signature of Patient or Legal Guardian Date Relationship to Patient

Patient / Guardian may be provided with a signed copy of this authorization form upon request.

Acct. # ______________ Reviewed By: ________