University Hospitals Urgent Care

Registration Form

PATIENT INFORMATION					
Last Name		First Name		Middle Initial	
Preferred Name		Sex	☐ Female ☐ Male	Date of Birth	
Address					
City		State		Zip code	
Primary Phone		Email Address			
Emergency Contact		Phone			

PLEASE LIST THE BEST PHONE NUMBER AND EMAIL WE MAY LEAVE MESSAGES WITH DETAILED MEDICAL INFORMATION			
Phone		☐	I do not consent to messages being left on my voicemail regarding my care.
Email		☐	I do not consent to messages or disclosure of medical information with anyone other than myself.
Primary Care Physician (PCP)	☐ NONE	PCP Phone	
PCP Practice/Hospital Association			

RESPONSIBLE PARTY (If self, skip to next section)					
Last Name		First Name			
Date of Birth		Email Address			
Insurance Company		Member ID		Group Number	
Medical Claims Address *(found on back of card)*					
Secondary Insurance Company *(if applicable)*		Member ID		Group Number	
Secondary Insurance Medical Claims Address					

SUBSCRIBER INFORMATION (If self, check *self,* and skip to next section)			
Relationship to Subscriber	◯ Self ◯ Mother ◯ Father ◯ Spouse ◯ Other (*Specify*):		
Last Name		First Name	
Subscriber Date of Birth		Subscriber SSN	

PLEASE LIST REPRESENTATIVE/S OR ENTITY OF YOUR CHOICE WE MAY DISCLOSE MEDICAL INFORMATION, INCLUDING MEDICAL RECORDS			
Last Name		First Name	
Phone		Relationship	

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Conditions of Service and Consent to Treat

PLEASE DO NOT SIGN THIS FORM WITHOUT READING THE ENTIRE CONTENT

By submitting this Consent Form (the "Conditions of Service and Consent to Treat") and agreeing to the Terms and Conditions set out herein, you ("you", "your", "undersigned representative acting on behalf of the Patient") provide your consent to the following:

Consent to Routine Medical Treatment/Services

Patient consents to the rendering of **Medical Treatment/Services** as considered necessary and appropriate by the attending physician or other practitioner, a member of the University Hospitals Urgent Care medical staff who has requested care and treatment of patient, and others with staff privileges at UHUC. Medical Treatment/Services may be performed by "Healthcare Professionals" (physicians, nurses, technologists, technicians, physician assistants, or other healthcare professionals). Patient authorizes the attending or other practitioner, the medical staff of UHUC to provide Medical Treatment/Services ordered or requested by attending or another practitioner, and those acting in his or her place. **The consent to receive "Medical Treatment/Services" includes, but is not limited to: urgent care; examinations (x-ray or otherwise); laboratory procedures; medications; infusions; drugs; supplies; anesthesia; surgical procedures and medical treatments; recording/filming for internal purposes (i.e. Identification, diagnosis, treatment, performance improvement, education, safety, security) and other services which Patient may receive**. In the event UHUC determines that Patient should provide blood specimens for testing purposes in the interest of the safety of those with whom Patient may come in contact; Patient consents to the withdrawing and testing of Patient's blood and to the release of test information where this is deemed appropriate for the safety of others.

Authorization to Release Information

UHUC is authorized to use and release information contained in the patient record as described in the UHUC Notice of Privacy Practices and as otherwise permitted or required by law. The information authorized to be used or released will include, but is not limited to, infectious or contagious disease information, including HIV or AIDS-related evaluations, diagnosis or treatment, information about drug or alcohol abuse or treatment of same and/or psychiatric or psychological information. Patient waives any privilege pertaining to such confidential information and hereby releases UHUC, its agents and employees from all liabilities, responsibilities, damages, claims, and expenses arising from the use and release of information as authorized above. Permissible uses and disclosures include, but are not limited to, disclosures to insurance companies, their agents, or other third-party payors and/or government or social service agencies that may or will pay for any part of the medical expenses incurred or authorized by representatives of UHUC. **PATIENT ACKNOWLEDGES AND AGREES THAT PATIENT'S RECORDS WILL BE AVAILABLE TO ALL UHUC AFFILIATED ENTITIES AND PROVIDERS, AND TO NON-UHUC AFFILIATED REFERRING PROVIDERS IN COMPLIANCE WITH THE PROVISIONS OF MEANINGFUL USE**. By consenting to treatment and accepting financial responsibility for any such treatment, Patient also understands and acknowledges that UHUC, may send Patient Satisfaction surveys, email, call and/or text the phone number Patient has provided with treatment-related information and patient financial responsibility balances.

Patient Financial Responsibility

Patient acknowledges they are financially responsible for any out-of-pocket expenses for medical services and treatment including copayments, coinsurance, deductibles, and services not payable by the patient's health plan. Co-payments are due at time of service. Patient agrees to obtain any necessary referrals prior to visit. Charges for all minors are the responsibility of the parent, guardian, or individual presenting the child for treatment. Patient acknowledges agreement to pay for all medical services and treatment provided at time of service if payment type is self-pay. Patient acknowledges medical services/treatment will be self-pay if active insurance information is not provided within 24 hours of medical services and treatment.

Acknowledgement of Patient Rights and Privacy Practices

By signing below, I acknowledge that I have received the United Hospitals Urgent Care **Patient Rights and notice of Privacy Practices and Individual Rights**. I acknowledge that I have read the above, am giving my consent to the above, and have been informed of my rights to privacy.

Printed Patient Name: _____

Signature of Patient or Parent/Guardian: _____ **Date:** _____