PATIENT REGISTRATION

Affinity URGENT CARE

Alvin . Texas City / La Marque . Galveston

Reason for your visit today: _____ Date: _____

Is this visit related to a motor vehicle accident or work-related injury? _____ NO _____ YES Date of Injury: _____

PATIENT INFORMATION

First Name: _____ Last Name: _____ MI _____

Date of Birth: _____ Social Security Number: _____ - _____ - _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home/Mobile Number: _____ Email: _____

INSURANCE INFORMATION

Primary Insurance: _____ Subscriber: _____ DOB: _____

Secondary Insurance: _____ Subscriber: _____ DOB: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____ Relationship: _____

Phone Number: _____ Second Phone Number: _____

CONSENT AND ACKNOWLEDGEMENT

I give permission for Affinity Urgent Care to disclose my health information to the individual/s listed below:

_____ _____

I, the undersigned, hereby acknowledge and consent to the following;

Treatment and Care: Administration and performance of all treatments, including diagnostic procedures/test that may be considered medically necessary

Medicare Patients: If you are a Medicare patient with a secondary insurance to your Medicare plan, it is your responsibility to provide both insurance identification cards. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. I authorize to release medical information about me to the social security administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Affinity Urgent Care. I acknowledge that I have been given Affinity Urgent Care Notice of Privacy Practice. I understand that if I have questions or complaints that I should contact the privacy official.

Authorization to Contact: You authorize Affinity Urgent Care personnel to communicate by mail, answering machine messages, and/or e-mail according to the information provided in your patient registration information. Affinity Urgent Care, or any agent or servicer of your patient account, may use any information you have provided, including contact information, e-mail addresses, cell phone numbers, and landline numbers, to contact you for purposes related to your account, including debt collection. You authorize Affinity Urgent Care to use this information in any manner consistent with the information you have provided, including mail, telephone calls, e-mails, or text messages. You expressly consent to any such contact being made by the most efficient technology available, including automatic dialing/e-mailing or similar equipment, or pre-recorded or other messages, even if you are charged for the contact.

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Payment Policies and Procedures
Payment in full for services and products are due at the time services are performed or products are ordered. As the patient/guarantor, you are financially responsible for any fees and costs associated with any services or products you receive from our office. This includes any medical service or visit, routine examination, testing, or screening ordered by the provider or staff. Co-payments will be collected at the time of service. Professional fees, services fees, co- payments and deductibles are not refundable. There will be a $35 fee for returned checks.

Payment by Credit Card/Credit Card on File: When you pay by Credit Card to be held on file, you agree to keep the credit card information current, and you authorize Affinity Urgent Care to securely store your credit card information, and only charge it should you have an outstanding balance or any leftover balance from a processed claim in the future. The storage system used is fully compliant to the highest level of credit card storage security regulations. Once stored, only the last 5 digits of your credit card are viewable by Affinity Urgent Care personnel. You understand that you are responsible for all charges for services that you receive from Affinity Urgent Care, and if the patient responsibility portion of your charges (including charges applied to your deductible and/or coinsurance) is not paid in full following receipt of the financial responsibility statement, then Affinity Urgent Care will bill your stored credit card for the outstanding balance due.

Minor Patients: The parent/guardian of a minor is responsible for payment of the minor's account balance. A minor who is not accompanied by a parent/guardian will be denied any non-emergency treatment unless charges for the treatment have been pre-authorized. Responsibility for payment of treatment of minor children, whose parents are divorced, rests with both parents.

Third Party Liability Injuries: If you receive treatment as a result of a third party liability injury (for example: motor vehicle accidents, premises liability, or other general liability claims against third parties), the balance for services rendered is considered due in full at the time of the service. Because Affinity Urgent Care does not protect charges incurred relating to or arising out of third- party liability, we will not accept a delay in payment due to settlement disputes and/or litigation. We will not accept a letter of protection from an attorney as a guarantee of payment or assignment of third- party insurance payments. Affinity Urgent Care cannot act as administrator to resolve financial arrangements. We may agree to bill a third-party insurance company of an at-fault party involved in an accident as a courtesy to you. To bill your claim directly, you must provide us all necessary information to confirm coverage for these payments with the auto/third-party carrier. We will also collect information about your personal medical insurance in case the auto/third-party carrier denies your claim. Regardless of whether we submit your claim to third-party insurance, as the patient, you are ultimately responsible for payment.

Workers' Compensation Cases: Charges for services incurred as a result of a verified work- related injury will be treated as workers' compensation, and we will bill the workers' compensation carrier as a courtesy. You must provide necessary information to bill the carrier. You are responsible for the completion of information with the employer and approval of the workers' compensation claim. In case your workers' compensation claim is denied, you will also provide us with your medical insurance information. If your claim is denied, we will bill your regular medical insurance carrier. When the claim is no longer pending and any portion of your claim is ultimately resolved against you by workers' compensation and your medical insurance, you will be required to pay all amounts due.

Registration Procedures: You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting verification of current insurance and paying any co-pays or other patient responsibility amount at each visit. Your card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be treated as a self-pay patient. As a self-pay patient, our fee is expected to be paid in full at the time of service. If the insurance card or other necessary information is furnished after the visit, we may file a claim with your insurance; and, if paid in full by your insurance, you will be reimbursed. If you are not prepared to make your co-pay or other patient responsibility amount, your visit may be re-scheduled by Affinity Urgent Care.

Privacy Policies: I acknowledge receipt of Affinity Urgent Care privacy policies.

I fully understand the this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. I understand that Affinity Urgent Care may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that Affinity Urgent Care will use and disclose my information for the purpose of treatment, payment, and healthcare operations as described in the of privacy practices. A photocopy of this consent shall be considered valid as the original.

I, the undersigned, certify that I have read, understand, and acknowledge the above statement and consents.

X _____ _____

Patient Signature | Signature Date