# Patient Registration Form

Last Name: ______________________ First Name: ______________________ M: ________

Preferred Name: ______________________

Street Address: ______________________ City: ____________ State: ______ Zip: ______

Birthdate: ______________________ SSN ______________________

Primary Language: ______________________ Do you need an Interpreter? ______________

How Did You Hear About Us? ______________________

Emergency Contact Name: ______________________ Phone ______________

Are you a veteran? (please circle) Y N VA Referred to our clinic? (please circle) Y N

Gender (please circle): Male Female Non Binary Other Prefer not to answer

- Race/Ethnicity(optional): ____________
- Declined to specify: ____________

Cell phone: ______________________ Other phone: ______________________

Email address: ______________________

Reason for today's visit: ______________________ Pharmacy: ______________________

Primary Physician's Name: ______________ Primary Physician's Phone Number: ______________

Do you have Medicare or a Medicare Supplement? (please circle) Y N

Primary Insurance ______________________ Secondary Insurance ______________________

Medicare Supplement Name ______________________

**Please complete this section if patient is under 18**

Name of person bringing in patient ______________________

Guarantor Name: ______________________ Relationship: ______________

Full Address: ______________________ Phone number: ______________

Guarantor DOB: ______________________ Guarantor SSN: ______________________

Guarantor Gender (please circle): Male Female Non Binary Other Prefer not to answer

**Please complete this section if being seen for a work related injury or work required exam**

Employer: ______________________ Employer Address: ______________________

Phone number: ______________ Contact Person: ______________________

Do you need an interpreter at your follow up appointment? (Please circle) Y N

## RELEASE OF MEDICAL INFORMATION

Patient's Name ______________________________ Date of Birth ______________________

I hereby authorize Health First urgent Care to disclose my individually identifiable information as described below. I understand this authorization is voluntary and may refuse to sign this authorization. I further understand my and the payment of my health will have no affect if I do not sign this form.

I understand this authorization is good for the current calendar year and will expire December 31st of this year.

I understand I may revoke this authorization at any time by notifying in writing to Health First Care's Richland or Pasco WA locations. I also understand the revocation must be signed and dated with a date later the date of this authorization. The revocation will not affect any releases made prior to the receipt of the written revocation.

I understand there could be a charge for photocopies and records in digital format as permitted by Washington State Law. Copies sent directly to other health care providers typically do not result in a charge but do require your authorization.

I understand my records may contain information regarding the diagnosis or treatment of HIV/ AIDS, sexually transmitted infections, drug and/ or alcohol abuse, mental illness, or a psychiatric condition.

I understand this release is not for Health First Marketing purposes. It is to establish proper communication preferences between patient and health care provider.

I understand information may be used for marketing research in efforts to improve operational processes and communicating with your insurance in accordance to our Privacy Practices.

I Authorize Communication via Text Messages, Detailed Voice Messages, and Email.

☐ Yes ☐ No ☐ Please Call but do not leave messages on Voicemail

Disclaimer: *This is not for communication obtaining protected health information. We do not email lab results. Please go to our website www.healthfirstuc.com to register to our patient portal.*

I authorize the release of the following medical records dated ____________________ to ____________________

To: Spouse ________________ Children ____________________ Organization/ Company ______________________

Address : ______________________________ Phone: ____________________ Fax : __________________

Medical Records to be released: (Please check all that apply) ☐ Billing Information

☐ All Medical Records ☐ Summary of Visit ☐ Imaging ☐ Other (Please Specify) ______________________

I would like to have this authorization to expire on this date: ______________________________

I authorize the Health First Urgent Care to obtain records dated ____________________ to ____________________

From: Organization/ Company/ Doctor's Office ______________________________

Address : ______________________________ Phone: ____________________ Fax : __________________

Medical Records to be released: (Please check all that apply) ☐ Billing Information

☐ All Medical Records ☐ Summary of Visit ☐ Imaging ☐ Other (Please Specify) ______________________

I would like to have this authorization to expire on this date: ______________________________

By signing this Form, I acknowledge I have read and agree to the terms on this document.

Patient or Authorized Person's Signature: ______________________ Date: ______________

If Signed by Person Other Than the Patient Please Print Name and Give Relationship:

______________________________________________

Employee/Witness Name: ______________________________ Date: ______________

# AUTHORIZATION AND CONSENT TO TREATMENT

Assignment of Benefits and Authorization to Release Medical Information. I hereby certify that the Insurance Information I have provided Is accurate, complete, and current and that I have no other Insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my Insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize Health First Urgent Care to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health Insurance plan does not pay Health First Urgent Care directly, I agree to forward to Health First Urgent Care all health Insurance payments which I receive for the services rendered by Health First Urgent Care and Its health care providers. I authorize Health First Urgent Care or any holder of medical Information about me or the patient named below to release to my health Insurance plan such Information needed to determine these benefits or the benefits payable for related services. I understand that If my Insurance plan does not participate In the Health First Urgent Care network, or If I am a self-pay patient, this assignment of benefits may not apply.

Guarantee **of Payment & Pre-Certification.** In consideration of the services provided by Health First Urgent Care and Its providers, I agree that I am responsible for all charges for services provided not covered by my health Insurance plan or for which I am responsible for payment under my health Insurance plan. I agree to pay all charges not covered by my health Insurance plan or for which I am responsible for payment under my health Insurance plan. I further agree that, to the extent permitted by law, I will reimburse Health First Urgent Care for all costs, expenses, and attorney's fees Incurred by Health First Urgent Care to collect those charges. If my Insurance has a pre-certification or authorization requirement, I understand that It Is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payments and that I will be responsible for all balances due. I have the right to ask for an estimate of what my charges might be.

Consent to Treatment. As a Health First Urgent Care patient, I voluntarily consent to the rendering of such care and treatment as Health First Urgent Care providers and personnel, in their professional judgment, deem necessary for my health and well-being. If I request or initiate a telehealth visit (a "virtual visit'), I hereby consent to participate in such telehealth visit and Its recording and I understand I may terminate such visit at any time. My consent shall cover medical examinations and diagnostic testing (including testing for sexually transmitted Infections and/or HIV, if separate consent Is not required by law), Including, but not limited to, minor surgical procedures (Including suturing), cast application/removals and vaccine administration. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my Health First Urgent Care provider nor any care center staff have made any guarantee or promise as to the results that may be obtained. Health First Urgent Care may retrieve Information and prescribe electronic prescriptions on my behalf.

Consent to Call, Email & Text. I understand and agree that Health First Urgent Care may contact me using automated calls, emails, and/ or text messaging sent to my landline and/or mobile device, these communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from Health First Urgent Care. I understand that I may optout of receiving such communications from Health First Urgent Care and Its partners by notifying Health First Urgent Care Richland at 37 Columbia Point Drive Richland, Washington, 99352, Health First Urgent Care Pasco at 4605 N Road 68 Pasco, Washington, 99301, by Informing my provider's staff or by calling 509-300-1500 or 509-367-6450 .

HIPAA. I understand that Health First Urgent Care Privacy Notice is available in the office and that I may request a paper copy at my care center's reception desk.

I hereby acknowledge that I have received Health First Urgent Care Financial Policy and Health First Urgent Care Notice of Privacy Practices. I agree to the terms of Health First Urgent Care Financial Policy, the sharing of my Information as described above and consent to my treatment by Health First Urgent Care providers. This form and assignment of benefits applies and extends to subsequent visits and appointments with Health First Urgent Care providers.

Printed Name of Patient:____________________________________

Printed Name of Signee if other than Patient: ____________________ Relationship: __________

Signature:______________________________Date:______________

To be signed by patient's'parent or legal guardian If patient Is a minor or otherwise not competent.

HEALTH FIRST URGENT CARE FINANCIAL POLICY

## PLEASE READ THOROUGHLY AND SIGN THIS SHEET

1. We will collect your deductible, co-pay, uncovered services, or the percentage you are responsible for at the time of your visit. Please be prepared to pay at the time of check-in before you are seen by the healthcare provider. **It is the patient's responsibility to know the terms of their insurance plan.**

2. You must bring your insurance card and photo I.D. with you and any authorization information you may have. Without these, we will be unable to see you.

3. We will file your insurance if we are providers for your plan. It is your responsibility to make sure we receive prompt payment from them. It is useful to maintain frequent contact with your insurance carrier to make sure they are paying as they should.

4. If your insurance denies payment on your account, you will be asked to pay by check, cash or charge. If you do not pay in a timely fashion, you will be responsible for all charges not paid by your insurance company in accordance with the laws.

5. SELF-PAY PATIENTS: This category includes patients with no insurance and the patients who have an insurance plan with which we do not participate. Payment for medical services is required prior to services being rendered. We accept Visa, MasterCard, Discover and American Express, checks, cash, and money orders. We will provide you with a receipt.

6. There will be a fee for any returned check amounting to $50 or any other fees passed on to us by the bank.

AS A FINAL NOTE:

Remember, you and/or your employer pay the monthly insurance premiums. Your insurance company is accountable to you. Do not hesitate to contact them if you disagree with their payment or to find out the status of your claims.

**If you have any questions regarding this financial policy, please ask or call BEFORE you are seen by the doctor.**

______________________________ ____________________

Patient or Guardian Signature Date

______________________________

Print Signee Name

______________________________

Print Patient Name