URGENT CARE USA, LLC

413 N. Alexander St.
Plant City, FL 33563
Ph: 813-752-7222
Fx: 813-752-7255

5464 Lithia Pinecrest Rd.
Lithia, FL 33547
Ph: 813-681-2111
Fx: 813-681-2611

Today's date:	Time:	Account Number:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Referred to clinic by: (please check one box)	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Reason For Visit:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ BCBS	❑ Aetna	❑ Cigna	❑ Humana	❑ Medicare

❑ Medicaid	❑ Tricare	❑ UHC	❑ Welfare *(Please provide coupon)*	❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

PLEASE READ CAREFULLY: AUTHORIZATION AND AGREEMENT FOR MEDICAL TREATMENT/CONSENT TO TREATMENT: I HERE BY CONSENT AND AUTHORIZE THE CLINIC TO PROVIDE ME TREATMENT AND CERTIFY THAT NO GURANTEE OR AGREEMENT HAS BEEN MADE AS TO THE RESULTS OBTAINED. INITIAL_____ AGREEMENT TO PAY FOR SERVICES: I PROMISE TO PAY URGENT CARE USA, LLC ALL CHARGES FOR ALL SERVICES RENDERED TO OR ON BEHALF OF THE PATIENT I THE UNDERSIGNED & OR THE PATIENT WILL BE RESPONSIBLE FOR ALL CHARGES, APPLICABLE, CO-PAYMENT & DEDUCTABLES OR CHARGES NOT PAID BY MY INSURANCE CARRIER. SUCH PAYMENTS WILL BE MADE TO URGENT CARE USA, LLC UPON THE RECEIPT OF STATEMENT. COMPLICATIONS: I UNDERSTANTD THAT IT IS MY RESPONSIBILITY TO RETURN TO THE CLINIC IF MY CONDITIONS CHANGE.PRIVACY NOTICES: I ACKNOWLEDGE THAT I HAVE READ URGENT CARE USA LLC'S PRIVACY NOTICE: INITIAL_____I AUTHORIZE URGENT CARE USA LLC TO SUBMITT A CLAIM TO MY INSURANCE CO. ON MY BEHALF. INITIAL _____

Patient/Guardian signature *Date*

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer

Urgent Care USA, LLC

Payment Policy

Thank you for choosing us as your urgent care provider. We are committed to providing you with quality and affordable health care. Because some of our patients had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided.

1. ***Insurance.*** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. *Knowing your insurance benefits is your responsibility.* Please contact your Insurance company with any questions you may have regarding your coverage.

2. ***Co-payments and Deductibles.*** All co-payments and deductible must be paid at the time of service. This arrangement is a part of your contract with your insurance company. If correct co-payment or deductible is not collected at the time of service, Urgent Care will bill the guarantor for the correct amount.

3. ***Non-covered services.*** Please be aware that some and perhaps all of the services you receive may be non covered or not considered reasonable or necessary by Medicare or other insurers. You must pay these services in full at time of visit.

4. ***Proof of Insurance.*** All patients must complete our patient registration form before being seen by the Doctor. We must obtain a copy of a valid for of Government identification and a current, valid insurance card. If you fail to provide us with the correct information in a timely manner, you may be responsible for the balance of a claim.

5. ***Claims submissions.*** We will submit your claim and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

6. ***Coverage changes.*** If your insurance changes, it is your responsibility to notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claims within 45 days from the date of service, the balance will automatically be billed to you.

7. ***Refunds.*** If an overpayment is made, all credits will be applied to the patient's account for future use, unless a refund is requested by the guarantor of that account. Refunds will be issued within 30 days from the date of the request.

8. ***Nonpayment.*** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

It is understood that all past due amounts due URGENT CARE U.S.A. will bear a finance charge at an annual percentage rate of 18% (monthly periodic rate of 1½%). Payment is due 10 days following the date of the invoice.

In the event the account of this applicant, is placed in the hands of an attorney at law for collection, or suit is instituted to collect the amounts due under the account of this applicant or any portion thereof, all costs reasonably incurred by Urgent Care USA, LLC including a reasonable attorney's fee, will be paid by the undersigned.

Thank you for understanding our Payment Policy. Please let us know if you have any questions or concerns.

I have read and understood the Payment Policy and agree to abide by its guidelines:

_____ _____

Signature of Patient or Responsible Party **Date**