Urgent Care of the Smokies

PATIENT REGISTRATION FORM

Please present your insurance card and a photo ID at time of check-in.
Settlement of patient financial responsibility is expected at the time of service.

TYPE OF VISIT:
☐ Insurance (present card at check-in) ☐ Self-pay (payment due at the time of service)
☐ On-the-job injury (Worker's Comp) ☐ Other: _____

Please STOP now and notify the receptionist immediately if you are experiencing any of the following:
SEVERE chest pains **SEVERE shortness of breath**
Uncontrolled bleeding **Allergic Reaction**
Any other life-threatening condition

Patient Information:
Please complete with the Patient's Full Legal Name

Last:		**First:**		**Middle:**
Social Security Number:	**Date of Birth:**	**Sex:** _____ Male _____ Female	**Email address:**	**May we send informational emails to you?** _____ yes _____ no
Home Phone: ___ Preferred		**Cell Phone: ___ Preferred**		**Work Phone: ___ Preferred**
Street Address:		**City, State & Zip:**	**Ethnicity/Race** *(Optional)*:	**Preferred Language** *(Optional)*:
May we leave a message regarding your care (x-ray, lab results, etc.) on your preferred phone? _____ yes _____ no		**Employer and Address:**	**Occupation:**	
Primary Care Physician's Name, Address & Phone Number:			**Would you like for information from your visit(s) to be forwarded to your primary care physician?** _____ yes _____ no	

Emergency Contact:

Name:	**Phone:**	**Relationship to Patient:**

Guarantor Information:
*Please complete with the Guarantor's Full Legal Name – **Guarantor is responsible party for the minor***

First:	**Middle:**		**Last:**
Relationship to Patient:	**Date of Birth:**	**Social Security Number:**	**Sex:** ____ Male ____Female
Home Phone: ___ Preferred	**Cell Phone: ___ Preferred**		**Work Phone: ___ Preferred**
Street Address:		**City, State & Zip:**	
Employer Name:	**Employer Address:**		**Employer Phone:**

PLEASE STATE THE REASON FOR TODAY'S VISIT:	**Is your visit today related to a motor vehicle accident?** _____ yes _____ no

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Primary Policyholder Information:		
Insurance Name:		
Last:	**First:**	**Middle:**
Date of Birth:	**Social Security Number:**	**Sex:** _____ **Male** _____ **Female**
Street Address: (if different from patient)	**City, State, Zip:**	**Relationship to Patient:**
Home Phone: ___ Preferred	**Cell Phone: ___ Preferred**	**Work Phone: ___ Preferred**
Employer:	**Occupation:**	**Other Emergency Contact:**

Secondary Insurance Information: *Please complete this section for secondary insurance or if the insurance card is NOT present!*		
Insurance Name:		
Policyholder Name: (who carries the insurance)	**Policyholder Date of Birth:**	**Policyholder Social Security Number:**
Employer:	**Occupation:**	**Copayment:**

How did you hear about us? ___Dr. referral ___existing patient ___friend/relative ___internet ___phonebook ___signage ___TV ___hotel ___cabin rental/resort ___radio ad ___work ___pharmacy

Authorization, Acknowledgment and Release for ALL Treatment at this Facility *(please initial)*

Authorization For Treatment: I voluntarily consent to the administration and cost of medical and surgical procedures, x-ray, and medication for myself and my dependents. **INITIAL** _____

Assignment of Insurance Benefits: I authorize payment directly to Urgent Care of the Smokies for all benefits and the release of medical information for all services and payments otherwise payable to me. **INITIAL** _____

Tenn Care Programs: I acknowledge that Urgent Care of the Smokies does participate in any Tenn Care program pursuant to the parameters of Tenn Care and claims will filed to these programs as primary or secondary insurance. I accept full financial responsibility for all bills due relating to these claims that Tenn Care does not pay. **INITIAL** _____

Guarantee of Payment: I understand that I am financially responsible and agree to pay all of the charges that are not paid or billed to insurance or any other third party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance copays today or remaining balances following insurance payment upon receipt of balance statement. If you are unable to verify my insurance at the time of service, I will pay in full for all services. A $25 fee will be applied to your account if it has been placed with a collection agency for non-payment and/or your payment has been returned by the bank for any reason. **INITIAL** _____

Release of Records: I authorize Urgent Care of the Smokies to release (verbal or in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or other health care operations, which may be liable to me or my practitioner(s) for charges for this treatment and for quality management, utilization review, transfer, and follow-up purposes. **INITIAL** _____

Receipt of Privacy Practices: I acknowledge that I have received & read the Urgent Care of the Smokies Notice of Privacy Practices. **INITIAL** _____

I understand that a copy of this agreement may be used with the same effectiveness as the original. INITIAL _____

Patient Signature_____ **Date** _____

Guarantor/Guardian (if applicable)_____ **Date** _____

Urgent Care of the Smokies

PATIENT REGISTRATION FORM

ACKNOWLEDGEMENT FORM

Patient Information: *Please PRINT with the Patient's Full Legal Name*				
First:		**Middle:**	**Last:**	
Date of Birth:	**Social Security Number:**	**Sex:** _____ **Male** _____ **Female**	**Ethnicity/Race** *(Optional)*:	**Preferred Language** *(Optional)*:

Please read the below carefully

When you visit Urgent Care of the Smokies, it is very important that you feel safe telling your physician personal information that may be required to fully diagnose or treat you. Urgent Care of the Smokies has strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. The Health Insurance Portability and Accountability Act ("HIPAA") rules require that Well-Key Health provide all of our patients with the attached Notice of Privacy Practices on their first visit. The Notice describes how the medical information we receive from you may be used or disclosed by Urgent Care of the Smokies and your rights related to your access.

Receipt of Privacy Practices: I acknowledge that I have received and read the Well-Key Health Notice of Privacy Practices.
I understand that a copy of this agreement may be used with the same effectiveness as the original.

Patient Signature _____ **Date**_____

Guarantor/Guardian (ifapplicable) _____ **Date** _____

Please tell us how to contact you to discuss your medical care

It is our policy to not release a patient's confidential and/or unauthorized information by telephone or voicemail except for appointment confirmation. Whenever returning phone calls, we do not leave a message in voicemail if the name or telephone number is not on the recorded message to identify it. Information will not be left with an unauthorized person who may answer the telephone.

If there is a need for a follow-up call from Urgent Care of the Smokies, LLC, I authorize the staff of Urgent Care of the Smokies, LLC to leave medical information pertaining to my care by the following methods and will assume responsibility to notify Urgent Care of the Smokies, LLC , in writing, if this information changes.

Call Home Phone:	Call Cell Phone:	Can Call Pager:	Can Call Work Phone:	Can leave a message on voicemail and/or answering machines:
___ yes ___no	___ yes ___no	___ yes ___no	___ yes ___no	yes no

Please specify the names of the people with whom we can discuss your medical care:

Spouse Name:	Parent Name:	Other Names including the Relationship:

If you prefer, please list a "unique identifier" as a way to confirm your identity when calling Well-Key Health. This unique identifier MUST be given before any information can be disclosed. (e.g. last four digits of SSN, mother's maiden name, etc.)

Identifier:

Receipt of Privacy Practices: I acknowledge that I have received and read the Well-Key Notice of Privacy Practices.
I understand that a copy of this agreement may be used with the same effectiveness as the original.

Patient Signature _____ **Date**_____

Guarantor/Guardian (ifapplicable) _____ **Date** _____