Patient Registration

Patient Last Name: _____

Patient First Name: _____Middle Initial _____

Social Security Number: _____Date of Birth: _____

Gender: Male Female Other_____ Sex at Birth: Male Female

Race: _____ Ethnicity: _____

Preferred Language: _____

Mailing Address:_____

City: _____State: _____Zip: _____

Home Telephone: _____ Mobile Telephone: _____

E-mail: (optional) _____ Marital Status: _____

Patient Employer: _____

Primary Care Physician: _____

Emergency Contact Name: _____ Phone Number: _____

Emergency Contact Relationship: _____

……

Insurance Card Holder/Guarantor: _____
Last Name First Name M.I.

Guarantor's Mailing Address: _____

Guarantor's City: _____ State: _____ Zip: _____

Guarantor's Social Security Number: _____ Date of Birth: _____

Gender: Male Female Other_____ Relationship to Patient: Parent Spouse

Guarantor's Employer Name & Address:
_____

Where did you hear about Makana North Shore Urgent Care?

Friend Letter Mailer Newspaper Internet

Phone Book Radio Relative Signage Work Other_____

Revision 11/21/2023

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Patient Financial Responsibility Form

Thank you for choosing Makana North Shore Urgent Care for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Copays are due at the time of service.
- Coinsurance, deductibles, and non-covered items are due 30 days from receipt of billing.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
    - Charge for returned check - $ _30.00__
- You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to pursue the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.
- You may be billed for phone calls from the medical provider if you require continued medical decision-making. There is no charge for a quick nursing phone call, appointment requests, or scheduling appointments (for dermatology). On average, a small percentage of calls are billed.
- By my signature below, I hereby authorize assignment of financial benefits directly to Makana North Shore Urgent Care and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Patient Name _____

Patient/Guardian Signature _____

Date _____

Revision 11/21/2023

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Credit Card Authorization Form

Makana North Shore Urgent Care submits claims to insurance carriers as a convenience to all our patients. At this time, we request authorization to balance bill a major credit card or debit card to cover amounts determined by your insurance to be your responsibility.

Upon receipt of an explanation of benefits from your insurance carrier any unpaid portion of your claim will be billed to your credit card or debit card. Should insurance pay in full, your account will not be charged.

All credit card/debit card information will remain absolutely confidential and securely stored by **First Data**. **Makana North Shore Urgent Care** will not store any banking account data.

I hereby authorize Makana North Shore Urgent Care to charge any and all outstanding balances, after insurance company reimbursement or denial, to my credit/debit card. I understand that I will not receive a statement if there is no balance due after processing my credit card for payment.

_____ _____

Cardholder's Authorization Signature **Date**

Our billing department will send you an email approximately seven days before prior to charging your credit/debit card for the remaining patient responsibility. Please legibly print the email address below where you would like to receive this notification. If this email address is not valid you may not receive the notification and your card will still be charged.

_____

EMAIL

Revision 11/21/23

RETURNING PATIENTS ONLY

Name: _____ Date of Birth: _____

CREDIT CARD/DEBIT CARD AUTHORIZATION

REQUIRED FOR EVERY VISIT

Makana North Shore Urgent Care submits claims to insurance carriers as a convenience to all our patients. At this time, we request authorization to balance bill a major credit card or debit card to cover amounts determined by your insurance to be your responsibility.

Upon receipt of an explanation of benefits from your insurance carrier any unpaid portion of your claim will be billed to your credit card or debit card. Should insurance pay in full, your account will not be charged.

All credit card/debit card information will remain absolutely confidential and securely stored by **First Data**. Makana North Shore Urgent Care will not store any banking account data.

I hereby authorize Makana North Shore Urgent Care to charge any and all outstanding balances, after insurance company reimbursement or denial, to my credit/debit card. I understand that I will not receive a statement if there is no balance due after processing my credit card for payment.

_____ _____

Cardholder's Authorization Signature **Date**

Our billing department will send you an email approximately seven days before prior to charging your credit/debit card for the remaining patient responsibility. Please legibly print the email address below where you would like to receive this notification. If this email address is not valid you may not receive the notification and your card will still be charged.

EMAIL: _____

REASON FOR VISIT:_____

Revision 11/21/2023

Medical Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: _____

Release of Information

You expressly consent and agree that, in order to discuss or service your account(s) (the "Accounts") or to collect amounts you may owe, Makana North Shore Urgent Care, and its officers, agents, affiliates, employees, and any affiliated, or associated service providers and any third-party debt collection agency associated therewith (collective, "We") may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contact you by sending text messages, emails, or using any email address you provide us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse: _____

Child(ren): _____

Employer: _____

Other: _____

Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call: My home □ My work My mobile number _____

If unable to reach me:

you may leave a detailed message.

please leave a message asking me to return your call.

_____

The best time to reach me is (day) _____between (time) _____

Signed: _____ Date: _____

Witness: _____ Date: _____

Revision 11/21/2023

Patient Receipt of HIPAA Privacy Notice

Dear Patient,

Makana North Shore Urgent Care is committed to maintaining the integrity of your protected health information and complies with all applicable state and federal regulations.

The federal privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA) have taken effect April 14, 2003. In support of our policy of complying with all applicable regulations, Makana North Shore Urgent Care provides patients with the HIPAA Notice of Privacy Rights.

While not required in order to receive treatment at Makana North Shore Urgent Care, we are obligated under federal regulations to ask that you sign an acknowledgement of the HIPAA Privacy Notice being made available to you.

Thank you.

Receipt of HIPAA Privacy Notice

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how Makana North Shore Urgent Care may use and disclose my protected health information. I understand that Makana North Shore Urgent Care reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

Printed Patient Name

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

.....

Office Use Only: To be completed only when a patient declines to sign acknowledgement.

Check here if patient declined to sign acknowledgement.

Staff Signature: _____ Date: _____

Refusal to sign acknowledgement does not prevent the patient from continuing to be treated.

To be filed in patient's record

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