emediate cure
QUICK CARE

Patient Registration Form

Open Everyday • 9 am to 9 pm.

PATIENT INFORMATION :

First _____ MI ____ Last _____ Gender M / F

Date of Birth ____/____/_____ Social Security# _____-_____-_____

Mailing Address _____ Apt/Unit #_____

City _____ State_____ Zip _____

Home Phone (____) _____-_____ Cell Phone (____) _____-_____

Email _____ @_____

PLEASE PRINT Providing your email above will allow use for Health communications and Billing, we will not distribute to third parties.

EMERGENCY CONTACT

Name_____ Phone _____ Relationship_____

PREFERRED Pharmacy

Name_____ Location_____

☐ **NO INSURANCE / PROMPT PAY**

PRIMARY Insurance Company_____

Guarantor's name (if not patient)_____ D.O.B. _____

Relationship to Patient_____

☐ **NO SECONDARY**

SECONDARY Insurance Company_____

Guarantor's name (if not patient)_____ D.O.B. _____

Relationship to Patient_____

IF PATIENT IS UNDER - Parent/Guardian

First Name _____ MI _____ Last Name_____ Gender M / F

Relationship to patient_____ Social Security# _____-_____-_____ D.O.B._____ /____ /_____

Address _____ Apt# _____City _____ State___ Zip _____

☐ Address same as above Cell Phone (____)_____-_____ Home Phone (____) _____-_____

Consent for services and disclosure of Protected Health Information

I hereby consent to medical evaluations, testing and/or treatment provided to me by the staff of Emediate Cure Quick Care. I also understand that Emediate Cure Quick Care may use or disclose any Protected Health Information (PHI) necessary to carry out treatment, payment or healthcare operations. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize the payment of insurance benefits, otherwise payable to me, to be paid directly to Emediate Cure Quick Care and I agree to pay any remaining balance once my insurance plan has processed my claim. I understand that I am responsible for any balance remaining due within 30 days of the first billing date. Any balance remaining after 30 days will be considered past due, I agree to pay interest at the rate of 18% per annum (1.5% monthly) on the balance due. Furthermore, in the event that my balance becomes past due Emediate Cure Quick Care has the right to refer any unpaid balance on my account to an attorney for collections and that in addition to any unpaid balance, I may be held responsible for the costs of collection including, but not limited to, court costs and attorney's fees.

X _____ Print Name_____ Date _____

Signature of patient or parent/guardian if minor

IMPORTANT: Please sign and date reverse side of this form.