Hastings Convenient Care PC

PATIENT INFORMATION:
Last Name_____, First Name_____ Sex M___ F___
Date of birth _____/_____/_____ Social Security Number _____

MAILING Address_____
City _____ State _____ Zip _____
Telephone numbers: Home_____ □ please indicate at which number
Cell_____ □ we may leave a message
Employer Name: _____Phone Number _____

Who is your Primary Physician? _____

HOW DID YOU HEAR ABOUT US? _____

For Minor Children Only: Parent/Legal Guardian Name _____
Parent Date of Birth_____ Parent Social Security Number_____
Employer Name/Phone #:_____
If different than patient: Address_____City_____State_____

Work comp only: Employer/Company Name _____
Supervisors Name _____Telephone Number_____
Address _____ City_____ State _____ Zip _____
Authorization for Visit? □ YES □ NO _____ (employee initial)

INSURANCE INFORMATION:

Primary _____
Member ID#_____
Group #_____Copay_____
Policy Holder_____
DOB_____ SSN_____

Secondary_____
Member ID#_____
Group #_____Copay _____
Policy Holder_____
DOB _____ SSN _____

RACE ***(Please check all that apply)***
□American Indian or Alaska Native
□Asian
□Native Hawaiian or other Pacific Islander
□Black or African American
□White
□Hispanic
□Other Race
□I do not wish to answer this question

EMERGENCY CONTACT_____Home#_____
Relationship to patient _____ Cell# _____

WHO CAN WE RELEASE YOUR INFORMATION TO?
Medical Release _____ Home #_____
Relationship to patient _____ Cell# _____

Financial Release _____ Home#_____
Relationship to patient _____ Cell# _____

CONDITIONS OF OFFICE VISITS

1. CONSENT FOR TREATMENT

I understand that I may have a condition requiring diagnostic procedures, physical examination and/or medical treatment. I hereby voluntarily consent to such diagnostic procedures (including, but not limited to, laboratory testing, and x-ray testing), physical examination and such medical treatment as deemed necessary by the health care providers. I further acknowledge that no guarantees have been made to me as to the results of treatment or examination provided at HASTINGS CONVENIENT CARE, P.C.

2. AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize HASTINGS CONVENIENT CARE, P.C. to furnish my medical record requested information or excerpts to any insurance company or third party payer for the purpose of obtaining payment of the account, or any entity providing care to the patient (medical specialist, hospital, radiology, oncology, pathology, imaging center, skilled nursing facility, health care facility). Also, to any relative or caregiver listed on the previous page.

3. FINANCIAL AGREEMENT

I agree, whether I sign as the patient or as the legal representative of the patient that in consideration of the services rendered to the patient that I individually obligate the patient and myself to pay the account. In the event of a payment being made with a check that is returned to us from the bank due to insufficient funds there will be a $25.00 NSF check fee and payment must be made with either cash, money order or cashier's check made out to Hastings Convenient Care, P.C. . Failure to pay for services provided will result in your account being turned over to Collections.
Arrangements that are different from this must be made with the office.

4. MEDICARE BENEFITS

Statement to Permit Payment of Medicare Benefits to Physician and *Patient.* I request payment of authorized Medicare benefits to me or on my behalf for any services furnished to me by HASTINGS CONVENIENT CARE, P.C. I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

5. NON-COVERED MEDICARE

The Medicare program has certain patient exclusion from coverage including, but not limited to, routine diagnostic work up and some routine physical examinations. If your medical chart indicates your office visit is for any of the above and for which no Medicare benefits are allowable, please be advised that all charges incurred during your office visit will be your financial responsibility.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, AND IS THE PATIENT OR IS DULY AUTHORIZED BY OR ON BEHALF OF THE PATIENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

_____

Signature of patient or authorized person **Date**

_____

Relationship to patient

_____

Witness