

Hastings Convenient Care PC

DEMOGRAPHICS PAGE

PATIENT INFORMATION:

Last Name _____, First Name _____ Sex M ___ F ___

Date of birth ____ / ____ / ____ Social Security Number _____

MAILING Address _____

City _____ State _____ Zip _____

Telephone numbers: Cell _____ please indicate at which number
Home _____ 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 _____

Secondary _____

Member ID# _____

Member ID# _____

Group # _____ Copay _____

Group # _____ Copay _____

Policy Holder _____

Policy Holder _____

DOB _____ SSN _____

DOB _____ SSN _____

RACE (Please check all that apply)

American Indian or Alaska Native

White

Asian

Hispanic

Native Hawaiian or other Pacific Islander

Other Race

Black or African American

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# _____

Hastings Convenient Care PC

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.

You understand we do not control the costs of radiology, or lab fees from an outside Radiologist/Radiology and or Pathologist/Laboratory.

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. .

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.

6. EXPRESSLY CONSENT AND AGREE THAT

In Order to discuss or service your account(s) or to collect amounts you may owe, Hastings Convenient Care, P.C. and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively, "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, using any e-mail address you provide to 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.

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