933 Centinela Ave. Suite B Inglewood, CA 90302 (310) 878-2858 inglewoodurgentcare@gmail.com

PATIENT REGISTRATION INFORMATION

Last Name:____ First Name:___________________________________

Date of Birth:_____________ Sex:_________ Social Security:_________________________

Address:____ Apt:___________

City:___________________________________ State:_________________ Zip Code:_____________________

Home Phone:________________________ Cell Phone:______________________ Email:____________________________

Primary Care Provider:____

Pharmacy of Choice:____ Pharmacy Phone:__________________________

Pharmacy Address:____

Allergies:____

Reason For Visit:____

Responsible Party Information (for patients under 18 and other dependent patients)

Last Name:__________________________________ First Name:_________________________ Date of Birth:__________

Relationship to patient:____

Address:____

City:____ State:________________ Zip Code:____________________

Emergency Contact:

Name:____

Phone:_______________________ Relationship to Patient:_________________________________

Patient's Primary Insurance Information __Self Pay	**Patient's Secondary Insurance Information**
Member Name:_________________________________	Member Name:____________________________________
Insurance Company:____________________________	Insurance Company:_______________________________
Subscriber ID #:________________________________	Subscriber ID #:___________________________________
Group #:______________________________________	Group #:____

Past Medical History:____

____

Surgical History:____

____

Current Medications:____

____

____	___________________________________	______________________
Print Patient Name or Legal Guardian Name	Signature of Patient or Legal Guardian	Date

MEDICAL SERVICES AGREEMENT (READ CAREFULLY BEFORE SIGNING)

PATIENT NAME: ____

1. MEDICAL CONSENT: I consent to any medical treatments or procedures that may be performed which may include but is not limited to medications, injections, taking of medical photographs, laboratory procedures, x-rays, and/or emergency services provided to me under the general instructions of the health care workers of Anaheim Urgent Care, Inc. and all its Associated Affiliates (herein referred to as “Inglewood Urgent Care”), assisting my care.

2. FINANCIAL AGREEMENT: I understand that all charges are due at the time of service. I agree to pay Inglewood Urgent Care for all charges for healthcare services provided to me. Acceptable forms of payment include Cash or credit card. If I am a noninsured patient, I agree to pay for my visit in full at the time of service. If Inglewood Urgent Care is a participating provider with my insurance company I understand that my co-pay, coinsurance, deductible and/or any outstanding balances are due at the time of service. I understand that my insurance policy is a contract between myself and my insurance company--Inglewood Urgent Care is not involved. I also understand that I am financially responsible for any services not covered by my insurance company. When my spouse or a financial guarantor signs this agreement, the spouse or the financial guarantor shall be jointly and liable with me. Should my account(s) be referred to an attorney or a collection agency for the collection, the undersigned shall pay the actual attorney’s fees and collections expenses incurred in addition to the other amounts due. Unpaid accounts referred to outside agencies for collection shall bear a reasonable interest from the date of referral.

3. INSURANCE AUTHORIZATION AND RELEASE: I request that payment of authorized benefits, including Medicare, and any other government sponsored program, private insurance, and any other health plans be made to Inglewood Urgent Care for any services furnished by that provider. To the extent necessary to coordinate my health care or determine liability for payment and to obtain reimbursement for services rendered, I authorize Inglewood Urgent Care to disclose portions of or all of my records, including my medical records to any person or corporation which is or may be liable for all or any portion of Inglewood Urgent Care charges, including but not limited to insurance companies, health care service plans, governmental agencies, or worker’s compensation carriers. I authorize UM to act as my agent to help me obtain any required pre-certification as well as acting as my agent to help me obtain payment from my insurance companies. I authorize my insurance companies to give Inglewood Urgent Care any information required to fulfill this function. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.

4. RELEASE OF MEDICAL INFORMATION: I hereby authorize Inglewood Urgent Care to release my medical health records to my primary care physician, if requested, to allow for continuity of care and any practitioner or hospital which I may be referred to assist in my care.

5. NOTICE OF PRIVACY PRACTICES: By signing this form, you acknowledge receipt of the Notice of Privacy Practices which provides how we may use and disclose your protected health information. We encourage you to read it in full.

6. IN-HOUSE PHARMACY: For my convenience, Inglewood Urgent Care can dispense some prescription medication(s) necessary to treat my medical condition(s). I understand that my insurance will not be billed for medication(s) dispensed and are an additional charge. If I prefer to use an outside pharmacy, a prescription can be provided to me at no additional charge.

7. PERSONAL VALUABLES: Inglewood Urgent Care shall not be liable for the loss of or damage to any personal property.

8. CREDIT CARD AUTHORIZATION: Our billing team will send a claim to your insurance company shortly after your visit. Once the claim is processed, your insurance company will send us a statement with the amount you owe. For your convenience, we will charge the credit/debit card you have left on file with us. There will be approximately 15 days from the time you receive the statement to the time your card is charged. If you would like to make other arrangements to pay off the balance or have questions, please contact us before the date on your statement. By signing this section, you are consenting to leave a credit/debit card on file with Inglewood Urgent Care and your card will be charged for any remaining balance you may owe. I certify that I am an authorized user of this card and agree with my card being charged as long as the transaction(s) correspond(s) to the terms indicated in this authorization form. I understand that this authorization will remain in effect until I cancel it in writing.

______________________	______________________	______________________
Card Holder Name	Signature	Email Address

Inglewood Urgent Care and the patient or the patient’s representative, hereby enter into this agreement. The undersigned certifies that he/she has read and agrees to the foregoing and is the patient, the patient’s representative or is duly authorized by the patient as the patient’s general agent to execute the above and accept its terms.

______________________	__________		______________________	__________
Signature of Patient	Date	or	Signature of Patient’s Representative	Date