

**PHYSICIANS PROMPT CARE CENTERS, LLC  
PATIENT REGISTRATION FORM**

**PATIENT INFORMATION**

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home# ( ) \_\_\_\_\_ Cell# ( ) \_\_\_\_\_ Email \_\_\_\_\_

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Sex: M F Social Security # \_\_\_\_\_

Status:      Minor      Dependent      Single      Married      Divorced      Widowed      Separated

Employer \_\_\_\_\_ Work# \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

Insured's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_

Address (if different) \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Social Security # \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

Insured's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_

*Circle all that apply*

May we leave test results on your:    home answering machine / cell phone voice mail / email?

May we leave test results with a specific family member:    Yes / No

    Name of family member \_\_\_\_\_ Relationship \_\_\_\_\_

    Phone # if different \_\_\_\_\_

**\*\*Due to federal mandates, we must ask the following questions. Your answers are optional.\*\***

*Please Circle*

Race:      American Indian      Asian      Black or African American      Native Hawaiian      White

Ethnicity:    Hispanic or Latino      Non-Hispanic or Non-Latino

Language:    English      Other \_\_\_\_\_

**Signature of Patient/ Responsible Party \_\_\_\_\_ Date \_\_\_\_\_**

**PHYSICIANS PROMPT CARE CENTERS, LLC  
HEALTH CARE CONSENT**

1. **CONSENT TO TREAT.** I for myself (or the patient named below), hereby consent to such diagnostic procedures and medical treatment as necessary and appropriate for my condition or illness in a Physician’s Prompt Care Centers (hereinafter “Prompt Care”) facility or for a course of treatment in the judgment of my physician(s), to be performed by the physicians, nurses, and other health care providers.
2. **RESPONSIBILITY FOR PAYMENT.** In consideration of the services to be rendered at Prompt Care, the undersigned agrees as patient or guarantor for patient, to pay Prompt Care for all services, facilities and supplies provided to me or the patient at the established rates, including any deductible, co-payment or charges not covered by third party payors. I accept responsibility for any costs, including attorney’s fees, incurred in the collection of these charges. I understand that if I do not consent to release of records or later revoke such consent, I am fully responsible for all charges for diagnosis and treatment received. I certify that the information given by me for purposes of payment for treatment at Prompt Care is to the best of my knowledge, complete and accurate.
3. **ASSIGNMENT OF BENEFITS.** In consideration of services rendered at Prompt Care, I hereby assign and authorize direct payment to Prompt Care and treating physicians, of any insurance, health plan or third party payor benefits otherwise payable to me or on my behalf for the medical services receive at Prompt Care.
4. **MEDICARE PAYMENT AND ASSIGNMENT OF BENEFITS (if applicable).** I request that payment of authorized Medicare benefits be made on my behalf for physician services furnished to me at Prompt Care and I assign such benefits to Prompt Care and providing same. I certify that the information given by me in applying for such benefits is correct and that I have completed a Medicare questionnaire. I authorize any hold of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed for payments of such benefits. I authorize the Social Security Administration to release information about my entitlement to benefits to Prompt Care and physicians providing services to me.
5. **RELEASE OF MEDICAL INFORMATION**
  - a. **GENERAL RELEASE.** I hereby authorize Prompt Care and any physician or other health care provider who may treat me to release any and all pertinent information contained in my medical records to:
    - i. Entities involved in billing and collection for Prompt Care, physicians services and third party payors responsible for payment of physicians charges (included but not limited to insurance companies, health benefit plans, employers involved in approval of benefit claims, government agencies or intermediaries representing any of the above);
    - ii. Any organization or government agency authorized to license medical officers or to review quality; utilization or cost of care rendered;
    - iii. Any person or organization involved in planning for transportation from Prompt Care; or
    - iv. Referring and follow-up health care providers after a visit to Prompt Care
  - b. **ACCESS TO PRIOR RECORDS.** I understand my treating physicians, nurses and other health care providers have access to any of my prior medical records in the custody of Prompt Care as needed to render appropriate care during my visit to Prompt Care.
  - c. **SPECIFIC RELEASE FOR MENTAL HEALTH, DRUG OR ALCOHOL ABUSE OR HIV INFORMATION:**
    - i. I hereby specifically authorize Prompt Care and any physicians or other health care provider who may treat me for mental health, drug or alcohol abuse, or HIV and related diseases, to release any and all information contained in my past or current medical records to the persons or organizations and for the purposes stated in 5.a and b. above. I agree that the specific consents contained in this paragraph shall apply even if I am diagnosed and/or treated for one of the above conditions after I have signed for the current visit to a Prompt Care facility.
    - ii. By initialing the diagnosis(es)/condition(s) below, then I do not consent to the release of such medical information, if any, to third party payors and understand that I am personally responsible for payment  
  
**Mental Health** \_\_\_ **Drug and Alcohol Abuse** \_\_\_ **HIV** \_\_\_
  - iii. **DURATION AND REVOCATION OF CONSENT FOR RELEASE FOR INFORMATION.** This consent to release information under this section “C” expires one year after the date of signature below. This consent may be revoked at any time by written notice to Prompt Care (with no effect on prior disclosures).
6. **PERSONAL BELONGINGS.** I assume full responsibility for all items of personal property, including, but not limited to eyeglasses, hearing aids, dentures, jewelry, currency and all other valuables.

I have read and understand the above terms of treatment and confirm that I am the patient or am authorized to sign on the patients behalf.

Patient Name: \_\_\_\_\_

Authorized Representative’s Name (if applicable):  
  
\_\_\_\_\_

Your insurance is out-of-network with Physicians Prompt Care and could be paid at an out-of network rate.  
  
\_\_\_\_\_

Patient’s (or Authorized Representative’s Signature):  
  
\_\_\_\_\_

Date: \_\_\_\_\_

**PHYSICIANS PROMPT CARE CENTERS, LLC**  
**NOTICE OF PRIVACY PRACTICES**

**Acknowledgement of Receipt**

Please review the above information carefully. Ask any questions about this information.

Please acknowledge your receipt of this notice of privacy practices that describes how we use your protected health information and your rights to access your health information by signing this statement on lines provided below.

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Please Print Your Name

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Signature

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Date