Family Choice
URGENT CARE

How did you hear about us?

____ Friend/Relative ____ Google Search ____ Newspaper ____ TV ____Radio

____ Community Event _____ Facebook _____ Drive By _____ Work _____ Doctor Referral

Reason for Visit: _____

Is This Visit Work Related? Yes / No If Yes, Employer? _____

Social Security Number: _____ Date of Birth: _____ Sex: ☐Male ☐Female

Patient Last Name: _____

Patient First Name: _____MI:_____ Marital Status: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Cell Number: _____ Home Number: _____

May We Leave a Detailed Message on Your Phone Regarding Your Care & Test Results? Yes No

Email Address: _____

Primary Care Physician: _____ Insurance Co-pay Amount: _____

Preferred Pharmacy (Local): _____

Request RX be dispensed in clinic if available ☐ Yes ☐ No

Race: ☐ Caucasian ☐ African American ☐ Asian ☐American Indian or Alaska Native

☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Patient Declines

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient Declines

Person Responsible for Payment (if different from patient):

Name: _____ Date of Birth: _____

Email: _____ Relationship to Patient: _____

P:541-213-2133 F:541-640-8107

www.familychoiceuc.com

Patient Receipt of HIPAA Privacy Notice

Dear Patient,

Family Choice Urgent Care is committed to maintaining the integrity of your protected health information and complies with all applicable state and federal regulations.

The federal privacy regulations of the Heath Insurance Portability and Accountability Act (HIPAA) have taken effect April 14, 2003. In support of our policy of complying with all applicable regulations, Family Choice Urgent Care provides patients with the HIPAA Notice of Privacy Rights.

While you not required in order to receive treatment at Family Choice Urgent Care, we are obligated under federal regulations to ask that you sign an acknowledgement of the HIPAA Privacy Notice being made available to you.

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how Family Choice Urgent Care may use and disclose my protected health information. I understand that Family Choice Urgent Care reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

_____

Printed Patient Name

_____ _____

Signature of Patient or Parent/Guardian Date

Office use only:

To be completed only when a patient declines to sign HIPAA acknowledgement. Refusal to sign acknowledgement does not prevent the patient from being treated.

Staff signature:_____ Date: _____

Who May We Speak to Regarding Your Care?

☐ Only Speak to Me Regarding My Care **Lifetime authorization or until revoked in writing**

Name: _____ Relationship: _____Phone Number:_____

Name: _____ Relationship: _____Phone Number:_____

Patient Financial Responsibility

Thank you for choosing Family Choice Urgent Care for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read, make appropriate selection and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.

We offer Self-Pay pricing for services provided. Payment is due in full at time of service. Self-pay rates <u>will not</u> apply after date of service. Insurance is not billed for these services.

- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of co-pays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Copays are due at the time of service.
- Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.
- Patients may incur, and are responsible for payment of additional charges, if applicable.
- Outside services such as lab work and imaging, may be referred and that I may receive a bill from providers outside of Family Choice Urgent Care.

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if
(1) you fail to pursue the claim for workers' compensation or (2) it is determined the Workers' Compensation Board that the illness or condition which required treatment was not a result of compensable workplace accident or occupational disease or
(3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law § 32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/services performed after the date the agreement is approved. if any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

You expressly consent and agree that, in order to discuss or service your accounts(s) (the "Accounts ") or to collect amounts you may owe, Family Choice Urgent Care, 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.

By my signature below, I hereby authorize assignment of financial benefits directly to Family Choice Urgent Care and associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Patient Name:

_____

Patient/Guardian Signature:

_____

Date:

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CREDIT CARD/DEBIT CARD AUTHORIZATION

Family Choice Urgent Care submits claims to insurance carriers as a convenience to all our patients. At this time, we request authorization to balance bill a major credit card or debit card (up to $250.00) to cover amounts determined by your insurance to be your responsibility.

Upon receipt of an explanation of benefits from your insurance carrier any unpaid portion of your claim up to $250.00 will be billed to your credit card or debit card. **I understand that I will receive an email notification of pending charges 7 days before my card will be processed.** Should insurance pay in full, your account will not be charged.

All credit card/debit card information will remain absolutely confidential and securely stored by **First Data**. Family Choice Urgent Care will not store any banking account data.

I hereby authorize Family Choice Urgent Care to charge any and all outstanding balances, after insurance company reimbursement or denial, to my credit/debit card. I understand that I will not receive a statement if there is no balance due after processing my credit card for payment.

Cardholder Print Name

_____ _____

Cardholder's Authorization Signature_____ **Date** _____

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Pre-Authorized Payments for Medical Care

Frequently-Asked Questions for Patients

Will my credit card be charged today? No. Under this pre-authorized program, the clinic will NOT be charging your card until we hear from your insurance about as to the amount that falls into patient responsibility or deductible. NOTE: You may be asked to make separate payments for your co-pay or other amounts today, but this has no effect on the pre-authorized payment program.

Will this be deducted from my available balance? No. This will NOT be deducted from your available balance today.

Are you keeping my credit card number on file? No. The clinic will not keep your credit card information in this office or in our system. Your information is securely saved with First Data, the largest processor of credit card payments in the USA. By signing for pre-authorized payments, we are only given permission to request to charge up to a specified maximum against your account within the next 90 days.

How much will you charge? You are authorizing us to charge up to $250.00. We will NEVER charge more than $250.00 on the credit card reserve.

What if my balance is more than what I am authorizing? We will charge $250.00 to your account, and you will receive an invoice in the mail for the remainder due.

How will I be notified of patient responsibility? Once your claim has been processed by your insurance company, our billing team will send an email to the address on file stating that your claim has been processed and there is a portion of today's visit that is patient responsibility, and your card will be processed in (7) days.

What if my balance is less than what I am authorizing? You are only authorizing us to charge you the balance due that is your responsibility for today's visit

Why does this clinic require payment pre-authorization? In the past, we have been stuck with many unpaid bills, and this unfairly increased the healthcare cost to patients who paid their bills. This policy allows us to assure all patients that they are paying their fair share of payments due.