Care United Medical Center

Close to home. Care you can trust.

Please print clearly so that we can process your information quickly and efficiently. Thank you!

Patient Registration

Date: _____ Social Security # of Patient:_____

Last Name _____ First _____ DOB: ____/____/____ Sex: M ( ) F ( )

Home Address _____ City _____State _____ Zip _____

Home No.: (_____) _____ Work No.: (_____) _____ Cell No.: (_____) _____

Preferred contact number? ( )HOME ( )WORK ( )CELL EMAIL ADDRESS: _____

May we leave a detailed message? ( )YES ( )NO Who may we discuss your care with?_____

Preference for reminders: ( )mail ( )wk phone ( )hm phone ( )cell ( )patient portal ( )decline to receive

Preferred Language:_____ Ethnicity: ( )Hispanic or Latino ( ) not Hispanic or Latino ( ) Unknown

Race: ( )American Indian ( )Asian ( )Black or African American ( )Native Hawaiin or other Pacific Islander ( )White ( )Other

( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed

Patient's Physician _____ Phone (_____) _____

* For your convenience, if you would like Care United to forward medical records to your physician please ask the staff for a "Medical Records Release" form.

What are we seeing you for today? _____

Are we seeing you today due to a motor vehicle collision?_____ If yes, was it within the last 24 hours?_____

If you answered YES to both questions STOP and advise the front desk personnel.

How did you hear about us? Please circle one.

Doctor Referral Friend Internet Mailer Phone Book Signage Work Other_____

RESPONSIBLE PARTY (if same as PATIENT, please put "SAME" on Guarantor line)

Guarantor Name: _____ Relationship to Patient: _____

Address City/State/ Zip _____

Home No.: (_____) _____ Work No.: (_____) _____ Cell No.: (_____) _____

Social Security # _____-_____-_____ DOB: _____/_____/_____ Sex: M ( ) F ( )

If patient is a minor, whom does the patient reside with? _____

Employer _____ Phone (_____)_____Ext. _____

FOR PATIENTS WITH INSURANCE

Primary Insured Name: _____ Relationship to Patient: _____

DOB: _____/_____/_____ Social Security #_____-_____-_____ Employer Name: _____

Insurance Company Name: _____ Insurance Co. Phone No.: _____

Insurance Company Address City/State/Zip: _____

Plan or Group # _____ Insured Id. No.: _____

LIFETIME AUTHORIZATION INSURANCE ASSIGNMENTS
AND AUTHORIZATION TO RELEASE INFORMATION

I. **RELEASE OF INFORMATION** - I, the below mentioned patient, authorize Care United Medical Centers of America to release to any third party payer or consulting physician any medical records concerning diagnosis and treatment when requested for its use in connection with determining payment for services rendered and/or further treatment and/or diagnosis.

II **PHYSICIAN INSURANCE ASSIGNMENT** - I, the below named subscriber, authorize payment directly to Care United Medical Centers of America for its services as described but not to exceed the reasonable and customary charge for these services. **I understand that my insurance may/or may not be in network with Care United Medical Centers of America and/or the physicians providing service.** I understand it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third party payer within a reasonable period of time not to exceed 60 days.

III **MEDICARE PATIENTS ONLY** – I, the below mentioned patient, understand my signature requests that payment be made directly to Care United Medical Centers of America and authorizes release of medical information to the centers for Medicare and Medicaid Services (CMS) and its agents. In Medicare assigned cases, the physician agrees to accept the allowed charge determination of the Medicare carrier and the patient is responsible for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are the determination of the Medicare carrier.

IV. I PERMIT A PHOTO COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT CARE UNITED MEDICAL CENTERS OF AMERICA'S OFFICE. **This assignment will remain in effect until revoked by me in writing.**
I understand it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid by my insurance or third party payer. Should your check for payment be returned for any reason, we will assess a $25.00 return check fee to your account. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. A $25.00 fee will be added to your account if it is sent to collections.

Date _____ Signature: _____

Patient Name: _____

Parent or Legal Guardian _____

ACKNOWLEDGEMENT OF REVIEW OF PRIVACY PRACTICES
(please see attached)

I have been offered and/or reviewed this office's Notice of Privacy Practices, which explains how my medical information will be disclosed. I understand I am entitled to receive a copy of this document.

_____ _____
Signature of Patient or Personal Representative Date

FINANCIAL POLICY

We would like to welcome you to Care United Medical Center, and are happy you have chosen us for your medical needs. Our goal is to provide you with the best possible care available. In order to meet this goal, we need your assistance and understanding of our patient policies. Our FINANCIAL POLICY is a necessary part of assuring the financial resources needed to maintain this vital health care facility for our patients and for this community.

INSURANCE COMPANIES

It is our office policy to collect the patient's responsibility for his/her care at the time of service. We are here to help answer any questions you may have regarding your insurance coverage and payments. However, your insurance is a contract between you, your employer, and the insurance company. We will first verify your insurance coverage. If we are a contracted provider with your plan, we will then collect your co-pay and file your claims directly to your insurance company. In the event your care is going to be applied to your deductible, you will be responsible for payment of your care at the time of service. We collect an ESTIMATE of your contracted rate; file your claim; and then send you a statement for any difference in what we collected at the time of your service and what your insurance company actually applied to your responsibility.

SELF PAY

Our office policy for self-pay patients is very simple. We require the cost of the office visit prior to seeing the physician. Any additional services such as lab, x-rays, etc. will be calculated and collected at time of check-out.

MEDICAID/CHIPS

Our providers are not contracted with MEDICAID/CHIPS. We are happy to provide your healthcare needs. However, you will be required to sign a PRIVATE PAY agreement and will be treated as a self-pay patient. This means you must pay for the office visit before services are rendered and pay for any additional services at time of check-out.

Again, thank you again for choosing Care United Medical Center. We believe it is important that our patients fully understand our financial policy so that we may concentrate on you and your medical needs.

_____ _____

Signature of Patient or Responsible Party Date

Consent to Obtain External Prescription History

I authorize Care United Medical Center to view and access my external prescription history electronically via the Rcopia.

I understand that my prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS

Patient Name (printed): _____

Patient (or Guardian) Signature: _____

Date Signed: _____