MED NOW URGENT CARE

Patient Name: First _____ MI _____ Last _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ - _____ Cell: ( ) _____ - _____ Other ( ) _____ - _____

Patient Email Address: _____ Birthdate: _____/_____/_____

Male _____ Female _____ Pharmacy _____ SSN# _____-_____-_____

Preferred Language: _____ Race and/or Ethnicity: _____

GUARANTOR Information (A guarantor is the person responsible for paying the bills.)

First _____ MI _____ Last _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ - _____ Cell: ( ) _____ - _____ Other ( ) _____ - _____

Email Address: _____ Birthdate: _____/_____/_____

SSN# _____-_____-_____ Patient's Relationship to Guarantor: _____

Financial Obligation for Med Now: I authorize payment of medical benefits to Med Now for services rendered. I understand and agree that I am financially responsible for the payment of all charges, that are my responsibility, for services provided, regardless of insurance coverage or other third party coverage unless waived by contractual agreements between Med Now and my insurer or if prohibited by state, federal laws or regulations. If the charges, that are my responsibility, are not paid within thirty (30) days of receipt of the bill, I agree to pay any additional expenses incurred due to the delinquent account, including collection agency cost, and/or reasonable attorney fees if applicable, if the account is placed for collection. All returned checks incur a $35.00 service charge or the maximum allowed by law, to be paid by cash or credit card along with balance of patients account within 10 days of notification by Med Now or its assigned agent. Failure to comply and meet financial responsibility may also result in a patient discharge from practice.

✔ Signature: _____ Date: _____

Emergency Contact? _____ Phone: ( ) _____-_____ Relationship? _____

1. Primary Insurance Co	2. Secondary Insurance Co	3. Tertiary Insurance
ID:# _____	ID:# _____	ID:# _____
Group # _____	Group # _____	Group # _____
Insured Person (owner of policy):	Insured Person (owner of policy):	Insured Person (owner of policy):
DOB: ___/___/___ SS# _____	DOB: ___/___/___ SS# _____	DOB: ___/___/___ SS# _____

Consent for Treatment: I, the undersigned, a patient of Med Now requests and authorize my attending physician and whomever he may designate as his/her associates or assistants, to administer such treatment as is medically necessary. I voluntarily consent to said medical care, evaluation and treatment as well as any information release necessary to obtain such. This would include such services, care, diagnostic procedures, and/or medical treatments as the physician deems reasonable and necessary. These would include, but not be limited to, the performance of services involving pathology, radiology and immunizations. In the event that invasive procedures are deemed medically necessary, I further understand that additional consent will be obtained and this consent might be verbal or written as circumstances dictate. I am aware that the practice of medicine and surgery is no exact science and I acknowledge that no guarantees have been made to me as to the results of treatment or examination.

✔ Signature: _____ Date: _____

Privacy Notice (HIPPA): by my signature below I acknowledge that the Health Insurance Portability and Accountability Act has been made available to me by Med Now and a copy provided, upon request, for me at my discretion. I hereby authorize Med Now to disclose information about myself (or another person for whom I have authority to sign) that is protected under federal law for the purposes of treatment, payment, and healthcare questions.

I acknowledge, that it is my responsibility as a patient or parent/guardian of Med Now to notify the office in regards to any changes of the information provided verbally or contained within this patient information form to include insurance, mailing address, custody of minors and/or health information. Signature required by patient, parent if minor child, guardian, or representative/caregiver if Medicare, for acknowledgement of the above *Consent of Treatment, Financial Obligation and Privacy Notice*.

✔ Signature: _____ Date: _____

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