MEDNOW
Urgent + Primary Care

Patient Name: First _____ MI _____ Last _____

Address: _____ Apartment #: _____

City: _____ State: _____ Zip: _____ Birthdate: _____/_____/_____

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

Email Address:_____ Male: _____ Female: _____

Pharmacy: _____ SSN: _____-_____-_____

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

Name: First _____ MI _____ Last _____

Address: _____ Apartment #: _____

City: _____ State: _____ Zip: _____ Birthdate: _____/_____/_____

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

Email Address:_____ Male: _____ Female: _____

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

Financial Obligation for Med Now/Urgent MD: I authorize payment of medical benefits to MedNow/UrgentMD 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 MedNow/Urgent MD 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 understand and agree that a 24% fee will be added to the balance 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 the patient's account within 10 days of notification by MedNow/UrgentMD or its assigned agent. Failure to comply and meet financial responsibility may also result in a patient discharge from practice.

✓**Signature:** _____ **Date:** _____

Primary Insurance Subscriber (owner of policy):_____ DOB:___/___/___ SSN: _____

Secondary Insurance Subscriber (owner of policy): _____ DOB:___/___/___ SSN: _____

Primary Care Physician Name: _____ Phone: _____

Address: _____

Consent for Treatment: I, the undersigned, a patient of MedNow/Urgent MD request 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 such 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 (HIPAA): By my signature below I acknowledge that the Health Insurance Portability and Accountability Act has been made available to me by MedNow and a copy provided, upon request, for me at my discretion. I hereby authorize MedNow/UrgentMD 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/guardian of MedNow/Urgent MD 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, mailing address, custody of minors and/or health information. Signature required by patient, parent if minor child, guardian, or representative/caregiver if Medicare, for acknowledgment of the above Consent of Treatment, Financial Obligation and Privacy Notice.

✓**Signature:** _____ **Date:** _____

E-Medication History Consent: MedNow/Urgent MD has transitioned to electronic medical records in order to provide you with greater treatment. We now have the ability to send and retrieve your medications electronically. Please sign below for permission to download your electronic medication history.

✓**Signature:** _____ **Date:** _____

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This authorization form permits MedNow/Urgent MD to use or disclose Protected Health Information listed in the Description section below to the Entity or Person listed in the Receiving Entity section for the following patient:

Patient Name: _____ DOB: _____ Phone #: _____

Address: _____ City/State/Zip: _____

The purpose of this authorization is to meet the patient's request for information disclosures and uses. The practice will verify the identity of any entity or person requesting Protected Health Information by verifying voicemail number, email address or name of authorized person(s).

Method(s) to release to you: Please fill out boxes for those methods you wish to receive your PHI and check boxes for authorized information.	**Person authorized to receive information on your behalf:** Please list the person's name, relationship to you and check information they are able to receive.
Voicemail Phone Number: _____ ☐ Appointment information ☐ Lab/test results	**Emergency Contact** Name: _____ Relationship: _____ Phone Number: _____ ☐ Appointment information ☐ Financial information ☐ Medical Information (please list) _____ ☐ Other _____
Fax: _____ ☐ Appointment information ☐ Financial information ☐ Medical Information (please list) _____ ☐ Other _____	* You may request another form for additional person(s).

This authorization shall be enforce until revoked by the patient or representative in writing.

Rights of the Patient

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

_____ Date _____
Signature of Patient or Personal Representative (as defined by HIPAA)

_____
Description of Personal Representative's Authority (attach necessary documentation)

OFFICE USE ONLY:
Receiving Employee: _____ Date Received: _____
☐ Copy given to patient
☐ Patient refused to sign