FASTER CARE PATIENT REGISTRATION

1. Last Name:	11.Primary Dr:
2.First Name:	12.Date of Birth:
3.Middle Initial:	13. SSN:
4.Mailing Address:	14.Sex: __Male __Female __Transgender Male to Female __ Transgender Female to Male
5.City:	
6.State:	
7.Zip:	
8.Home Phone:	
9.Cell Phone:	
10.Work Phone:	

INSURANCE POLICY HOLDER (SKIP IF PATIENT IS POLICY HOLDER)

1.Last Name:	6.Address:
2.First Name:	7.City:
3.DOB :	8.State:
4.SSN:	9.Zip:
5.Sex:	

FINANCIALLY RESPONSIBLE PARTY (SKIP IF OVER 18 YEARS OLD)

1.Last Name:	6.Gender:
2.First Name:	7.Address:
3.DOB:	8.City:
4.SSN:	9.State:
5.Phone:	10. Zip:

LIST MEDICAL INSURANCES IN ORDER:

Primary Insurance:	_____
Secondary Insurance:	_____
Tertiary Insurance:	_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I also authorize Faster Care or my insurance company to release any information required to process my claims. I consent to treatment by the physicians of Faster Care and to appropriate tests for the presence of infection, such as, but not limited to Hepatitis B Virus, Hepatitis C Virus, or HIV if deemed necessary and authorize the withdrawal of blood or other body fluids for this purpose.

RECEIPT OF NOTICE OF PRIVACY PRACTICES: I verify that I have received a copy of Faster Care's notice of privacy practices.

I am aware that ALL radiographic studies including but not limited to x-rays, cat scans and ultrasounds will be read by a radiologist who will require a separate payment. All laboratory procedures not executed at Faster Care will also require a separate payment. The patient will be responsible for these charges, not Faster Care.

Payment for the patient portion will be collected at the time of service, including co-pays, coinsurance, and any portions of your unpaid deductible. Collection accounts will receive a $50.00 charge on all unpaid balances. Bounced checks will receive a $30.00 charge.

X Patient Signature OR Signature of parent if the patient is a minor: _____ Date: _____

FasterCare

When you need care NOW!

PATIENT PORTAL REGISTRATION FORM

*The patient portal gives you quick and **easy access to your medical record** and is the preferred method of Faster Care. **Manual request for records** must be picked up by the patient or authorized individual on file and **may take up to 2 weeks.***

The patient portal provides secure online access to the following:

- View Medical Records and Lab Results
- View and pay bills
- Update address, phone number, and pharmacy information on file we well as list emergency contacts.
- Secure messaging to our office for general and billing questions

Patient Name (Print): _____ Date Of Birth: _____

(If patient is under the age of 16 parent/guardian must be listed)

Parent/Guardian (If Applicable): _____

E-mail Address (Print) : _____

OR

___ I do not want to be web enabled.

By signing and dating this form, I am authorizing Faster Care to create a patient portal Logon ID and password for that patient listed above. I understand that this information will be e-mailed to me within three business days at the e-mail I have provided above.

Signature: _____ Date: _____

OFFICE USE ONLY: ID VERIFIED : ____ DATE RECEIVED/COMPLETED: _____ INITIAL: _____

Authorization for the Use and Discloser of Protected Health Information

I hereby authorize Faster Care to use and disclose my Protected Health Information as described below.

I understand that the information I authorize a person/facility to receive may be re-disclosed and no longer protected by state and federal regulations.

Patient Name (Last, First):_____

Address: _____ Telephone Number: _____

Last four of SSN: _____ Date of Birth:_____

Name of Person/facility Authorized to Receive the Information:

Name (Last, First): _____

Address: _____ Telephone Number: _____

City, State, and Zip Code: _____ Fax Number: _____

Purpose of Disclosure: _____

Dates of Treatment: ___ All **OR** Specific date range: _____ to _____

Information to be Used/Disclosed – CHECK all that apply:

__Entire Medical Record __ Billing Summary **Other:** _____

__ Progress Notes __Radiology Reports

__ Laboratory Report __Radiology Imaging Disks

I must Separately authorize the following if desired – CHECK all that apply:

__Alcohol abuse/treatment record __Mental Health Treatment

__Drug abuse/treatment record __STD/HIV Status/Treatment

Requested Method of Deliver CIRCLE all that apply Pick up Fax Verbal Mail (to address on this form)

Expiration Date : 90 days from Signature date OR Specific Date: _____

- You may ask for a copy of this authorization.
- This authorization will expire on date you indicated above. You may revoke this authorization at any time by submitting a written request to Faster Care. Your revocation will be honored except to the extent that it has been acted upon in good faith while in force.
- The information you are authorizing to be released could be re-released or disclosed by the recipient. Such additional disclosures or releases may not be prohibited by law. We are not responsible for the actions of others who may be provided with information released as a result of this authorization.
- You will be responsible for requesting to update this form upon designated expiration date.

Signature of patient/legally qualified Representative: _____ **Date:** _____

Print name of patient/ legally qualified representative:_____

****Legal documentation must be obtained to released upon request of legal representative.****

Faster Care 3440 Declaration Blvd. Sumter, SC 29154
Phone : 803-905-3278
Fax: 803-905-3282