Dr. Jon
Urgent Care Center

Patient Registration

Patient Name (First, Middle, Last): _____

SSN: _____ Sex: Male / Female Marital Status: _____ Date of Birth: _____

Primary Care/Provider Name: _____ PCP Phone: _____

Pharmacy (Name / Location): _____

Mailing Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Email: _____

Contact Numbers

Home : _____

Cell : _____

Emergency Contact Name : _____

Relationship : _____

Emergency Contact Phone # : _____

Patient:

Employer Name : _____

Work Number : _____

AI Charting Consent: I understand that this office uses secure Artificial Intelligence (AI) tools to assist with medical charting and documentation. All information is handled in accordance with privacy and confidentiality laws.
By receiving care here, I consent to the use of AI for these purposes:

Patient / Responsible Party Signature: _____ **Date:** _____

Responsible Party— Complete for Minor Patient OR when Patient is NOT Financially Responsible for Account

Name of Person Responsible for this Account: _____

Relationship: _____ Date of Birth: _____ SSN: _____ Phone: _____

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

Patient's Financial Responsibility/HIPAA

You agree, in order for us to service your account or to collect any amounts you may owe us, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded / artificial voice messages and/or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that **Dr. Jon's Urgent Care** may contact me/us as described above. I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office is due at the time of service. I also understand that charges not covered by insurance remain my responsibility and assign insurance benefits to this office. I agree to pay all late fees, costs of collection fees, and/or attorney's fees and all court costs, if any.

Patient / Responsible Party Signature: _____ Date: _____

Our practice is dedicated to maintaining the privacy of your individual identifiable health information (PHI). We are required by law to make this available to you. Our office has a copy of our current Privacy Practices posted in our lobby. This notice is also available on our website and you may request a written copy of our most current notice at any time. Please sign below indicating that you have read and understand your rights to receive a copy of this notice.

Please list the names of the person/persons to whom we may disclose the patient's (PHI) Patient Health Information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient / Responsible Party Signature: _____

Date: _____