FAMILY'S HEALTH CARE
Para la salud de toda la familia
Se Habla Español

A. PATIENT INFORMATION(Use name on birth certificate or insurance)

Last Name:_____ Date of Birth:____/_____/_____
First Name:_____ Gender:_____
Middle Name:_____ Language:_____
Address:_____Apt:_____ Race(s) or Ethnic:_____
City:_____State:_____ Prefer Phone #:_____
ZIP CODE:_____ E-mail:_____

Do you give Family's Health Care permission to send you text messages regarding appointments or feedback:____yes___No

B. IF CHILD IS BEGIN SEEN MOTHER/GUARDIAN #1 INFORMATION ___Step Parent____Other

Last Name:_____ Home #:_____
First Name:_____ Work #:_____
Address(if different than child's):_____ Cell #:_____
_____ E-mail:_____
_____ Employed by:_____
DOB:___/___/____SSN:_____

C. IF CHILD IS BENING FATHER/GUARDIAN #2 Information_____Step Parent_____Other

Last Name:_____ Home #:_____
First Name:_____ Work #:_____
Address(if different than child's):_____ Cell #:_____
Employed by:_____ E-mail:_____
DOB:____/____/_____SSN:_____

C.PREFERRED EMERGENCY CONTAC (Must be different from above in section B)

Last Name:_____ Relationship with patient:_____
First Name:_____ Phone #:_____
Address(if different that child's):_____ E-mail:_____
_____

AUTHORIZED TO BRING PATIENT TO OFFICE, DISCUSS MEDICAL INFORMATION AND MAKE MEDICAL DECISIONS:
Person #1:_____
Person #2:_____
Person #3:_____

D. INSURANCE

Medicaid Number (Red and White card)_____

MCO:_____ MCO ID Number:_____

If you being covered by any other insurance (private insurance through a job, parent or spouse, etc.)? **YES/NO**
***PLEASE NOTE: According to Maryland Medicaid, if you have any other medical insurance, Medicaid is always the payer of last resort and your private policy will be billed first, provided that benefits are properly coordinated. You Must disclose your primary insurance to Medicaid.** If you fail to repot any other insurance, visit are retracted, you will be responsible for yours or your child's balance.

D. PIVATE INSURANCE

Primary Insurance_____ Subscriber ID#_____
Subscriber Name_____ Employers Name_____
(Person who enrolled into health plan) Employers Phone #_____
Subscriber DOB_____/_____/_____ Subscriber SSN_____
Relationship to patient:_____

Secondary insurance Name (if other than Medicaid)_____

Subscriber Name_____ Subscriber ID #_____
(Person who enrolled into health plan) Employers Name_____
Subscriber DOB_____/_____/_____ Employers Phone #_____
Relationship to patient:_____ Subscriber SSN_____

E. CONSENT & AGREEMENT

I hereby consent to the use and disclosure of my Private Health Information (PHI) and individually Identifiable Health Information (IIHI) for payment, treatment and other healthcare operations, according to the health insurance Accountability Ano portability Act of 1996, effective April 14, 2003. I have been given an opportunity to review a copy of the Privacy Notice. I understand that patient information will still be stored electronically for my provider's record.
I have reviewed the Children's IQ Network (CIQN) Information Sheet. I understand that patient information will still be stored electronically for my provider's record, and that an electronic health summary will be available to other providers through the CIQN. I also understand that I have the right to not share (opt-out) health information with other providers within the CIQN. (Please request a form if you'd like to opt-out)

I hereby authorize the release of patient medical information to insurances carriers and authorized my insurance benefits to be Paid directly to Family's Urgent Care, realizing that I am responsible to pay unpaid services. The medical Services will be Summited to my insurance company base on the information I have provided. If payments has not been received within 60 days Of service OR payment has not been received due to incorrect insurance information being given to Family's Urgent Care at time of service, the account will be turned over to an outside collection agency with additional fees added.

The undersigned hereby consents to the administration of such medical treatment, diagnostic and/or therapeutic procedures And surgery as required by the physician rendering care for themselves and/or their child(ren).

Patient/Parent/Guardian signature:_____
Parent/Guardian Print Name:_____
Today's Date_____/_____/_____