Xpress Urgent Care Registration Form

(**Please Print**)		
Today's Date:	Reason for Visit:	
Work Related: Yes ❑ No ❑	MVA Related: Yes ❑ No ❑	Name of Primary Care Physician:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital Status (circle one)
					Single / Mar / Div / Sep / Wid

Is this your legal name?		If not, what is your legal name?	*E-mail:	Birth Date:	Age:	Sex:	
❑ Yes	❑ No			/ /		❑ M	❑ F

Street Address:	Cell/Home Phone No:	OK to Leave a Message
	( )	Yes ❑ No ❑

City:	State:	Zip:	Social Security No:

Occupation:	Employer:	Employer Phone No.:
		( )

How did you hear about Xpress (please check one box):	❑ Dr.		❑ Insurance Plan	❑ Hospital
❑ Family	❑ Friend	❑ Close to home/work	❑ Social Media	❑ Other ______________________________
Pharmacy Name:		**Pharmacy Address:**		

INSURANCE INFORMATION

Name of Primary Insurance :

Subscriber's name:	**Subscriber's S.S. No.:**	**Birth Date:**	**Policy No.:**	**Group No.:**
		/ /		

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

Name of secondary insurance:	Subscriber's name:	Policy No.:	Group No.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

EMERGENCY CONTACT

Name:	Relationship:	Contact No: ( )	OK to Release Personal Health Information Yes ❑ No ❑

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **Xpress Urgent Care** or insurance company to release any information required to process my claims.
I hereby authorize the healthcare staff to perform the necessary services I may need. By providing email address and consenting to receive voicemails, I authorize Xpress Urgent Care to leave a detailed voicemail message, including lab and diagnostic test results, as well as locations, hours of operation and marketing information, on the following authorized phone number and email.

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Patient/Guardian Signature *Date*

XpressFL.com
1-855-977-3775

Patient Name: ____ DOB: _________________________

CONSENT, ASSIGNMENT, AND RELEASE FORM CONSENT FOR MEDICAL TREATMENT

I voluntarily present to Xpress Urgent Care and consent to treatment of the medical provider on duty and whomever they may designate as their assistant, associate, treating physician and patient care staff to provide my care. Such care may include, but is not limited to, diagnostic procedures, radiological evaluations and procedures, and the administration of medications considered advisable in my diagnosis, treatment, and course of care. I acknowledge that no guarantee can be made or has been made as to the results of treatments or examinations and I understand that all medical treatments contain inherent risks.

ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT GUARANTEE

In consideration of services provided, I hereby assign and transfer to Xpress Urgent Care any and all rights, which I have against insurance companies or third-party payers, for payment of charges for services provided by Xpress Urgent Care to me or to one of my dependents. I authorize said payments to be applied to any unpaid balance for which I am responsible. I understand that I am responsible for and will pay the portion of my bill not covered by insurance companies or third-party payers. I agree to pay the account in full upon receipt of my billing statement unless payment arrangements are made with Xpress Urgent Care.

HIPAA COMPLIANCE & RELEASE AND USE OF PATIENT INFORMATION

In compliance with the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), Xpress Urgent Care must inform you that you have certain rights to privacy regarding your protected health information. You understand that this information can and will be used to conduct, plan and direct your treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. You also hereby assert that you have presented to Xpress Urgent Care voluntarily for your medical needs and that as part of the evaluation of your condition and any required treatment, the medical provider on duty may determine that particular laboratory, diagnostic, and radiographic tests may be needed. Xpress Urgent Care offers many of these services on-site as a convenience to our patients. If any patient would like to have their laboratory or radiographic services provided at another location it is your right to do so.

I authorize the release of my medical records, information, treatment and advice, and specific health information to:

1. TREATING MEDICAL PROVIDERS on staff at Xpress Urgent Care and their staff, agents of another healthcare facility if direct transfer to another facility is required, and to my primary care physician or any referred consultants for follow up care.
2. AN EMPLOYER who requests services. This may include your personal medical history, physical, laboratory and diagnostic tests, and drug screenings (including the presence of drugs, alcohol or marijuana).
3. INSURANCE COMPANY or other third-party payer and their agents as well as any review organization or government agency for the purpose of determining eligibility and available benefits, obtaining payment for services provided, and insuring government compliance.

I understand that if I refuse to authorize access to my records for coordination of care, my treatment could be adversely affected and that I could be held liable for the full cost of services provided by Xpress Urgent Care. I understand this information may contain my personal medical history, physical, and treatments (if necessary), radiographic and laboratory results, and more specifically results in reference to alcohol/drug abuse, mental health, or infectious disease (including human immune-deficiency virus, hepatitis, or other infectious diseases). I understand that I have the right to revoke this authorization.

RECEIPT OF HIPAA PRIVACY NOTICE

I acknowledge receipt of the Notice of Privacy Practices with detailed information about how Xpress Urgent Care may use and disclose my protected health information. I understand that Xpress Urgent Care reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me upon request.

Signature of Patient or Parent/Guardian: ____ Date: ________________

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FINANCIAL POLICY

Payment for services is due at the time services are rendered.

Methods of payment: Cash, American Express, MasterCard, VISA, and Discover.

We are happy to assist you in processing your insurance claim, however, insurance coverage is a contract between you and your insurance company, and you are ultimately responsible for payment of your bill.

I understand that I may be billed for any out of pocket or reasonable collection fees if my account is not paid in a timely fashion. If it becomes necessary to pursue legal action to attempt to collect any outstanding balances, I agree that I am responsible for any and all attorney fees, court costs and any and all other costs deemed reasonable and customary and/or that may be allowed by the Court.

____ ____________________________

Signature of Patient **Date**

____ ____________________________

Signature of Policyholder / Responsible Party **Date**

(if other than patient)