Urgent Care Center
MEDSTOP
Madonna Plaza SLO

283 Madonna Road, Suite B, San Luis Obispo, CA 93405
(805) 549-8880 FAX (805) 783-2009

PATIENT INFORMATION SHEET

****ALL INFORMATION MUST BE PROVIDED FULLY & ACCURATELY FOR REGISTRATION****

PRINT CLEARLY

LAST NAME		FIRST NAME	
DATE OF BIRTH		AGE	SEX AT BIRTH: M F GENDER IDENTITY:
MAILING ADDRESS		CITY STATE	ZIP CODE
STREET ADDRESS		CITY STATE	ZIP CODE
HOME PHONE	CELL PHONE	SOCIAL SECURITY#	MARITAL STATUS S M D W
EMAIL ADDRESS			
OCCUPATION		EMPLOYER NAME	
EMERGENCY CONTACT NAME		PHONE NUMBER	

RESPONSIBLE PARTY BILLING INFORMATION

RESPONSIBLE PERSON	RELATION TO PATIENT	DATE OF BIRTH	DAYTIME PHONE

INSURANCE (present insurance card for verification of coverage)

NAME OF INSURANCE COMPANY	MEMBER NUMBER	
NAME OF INSURED (if not SELF)	DATE OF BIRTH	RELATION TO PATIENT

PREFERRED PHARMACY

*PRESCRIPTIONS ARE SENT ELECTRONICALLY – FAILURE TO PROVIDE THIS INFORMATION MAY NOT ALLOW FOR PRESCRIPTIONS TO BE WRITTEN

PHARMACY NAME	ADDRESS	CITY

PRIMARY CARE PHYSICIAN

PCP NAME	CITY	PHONE

PLEASE COMPLETE AND SIGN BACK SIDE NOW

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MED STOP URGENT CARE CONSENTS

PLEASE SIGN BELOW ACKNOWLEDGING ALL CONSENTS LISTED

If you would like to designate someone with whom we can discuss your medical care or request your medical records, to include if my medical or billing and/or treatment records contains information in reference to: drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis testing, genetic testing or diagnosis and/or other sensitive information, or treatment records that contain information in reference to HIV/AIDS testing or diagnosis I agree to its release. Including release of records to yourself. Please complete the following;

MEDSTOP URGENT CARE CENTER is authorized to release/discuss protected health information regarding my medical care to persons listed below:

PRINT NAME	PHONE NUMBER
_____	_____
_____	_____
_____	_____

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL WITHDRAWN, BY THE PATIENT, IN WRITING.

You expressly consent and agree that, in order to discuss or service your Accounts(s) or to collect amounts you may owe, Med Stop Urgent Care Center, and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively, "We") may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contract you by sending text messages, emails, using any e-mail address you provide to us, or by pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result."

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

I give consent for pharmacy reconciliation by my signature on this form.

·Release of Information · Assignment of Benefits ·Notice of Privacy ·Acceptance of Financial Responsibility

- **I authorize the release of medical information** to my primary care physician as identified in my medical records and/or to any physician to whom I may be referred.
- **I authorize direct payment of medical benefits** to MEDSTOP URGENT CARE CENTER and the release of my medical information or other information necessary to process this claim, to my insurance company.
- **I have received a copy** of the MEDSTOP URGENT CARE CENTER Notice of Privacy Practices.
- **I understand that I am ultimately responsible for payment** of charges, regardless of my insurance status, including responsibility for co-payment, deductible, amounts above allowable and non-covered/denied services. We are not contracted with MediCal/CenCal or any State based Medicaid programs.
- **CONSENT FOR TREATMENT**
  Consent is hereby given to MEDSTOP URGENT CARE CENTER and the treating practitioner to administer such treatment and to perform such medical and/or surgical procedures as they deem necessary.

Patient Signature: _____ Date: _____

Relationship if other than self: _____