im | HEALTH

372 West Lancaster Ave
Wayne, PA 19087

Patient Registration (3 Pages)

Reason for Visit: _____ **DATE:** _____

Is this a WORK related problem? YES____ NO____ **Is this AUTO ACCIDENT related? YES____ NO____**

First Name: _____ **MI:** _____ **Last Name:** _____

DOB: _____ **Social Security #:** _____

Gender (circle one): M | F | Prefer not to Specify **Marital Status:** _____

Race: _____ **Ethnicity (circle one):** Hispanic/Latino | Not Hispanic/Latino

Address: _____
Street City State Zip

Preferred Phone Number: _____ (**circle one):** Home / Cell / Work

I allow IM | Health to text me health information and appointment reminders

___ Yes ___ No

I allow IM | Health to leave voice messages with health information and appointment reminders

___ Yes ___ No

Email Address: _____

I would like to be web-enabled ___ Yes ___ No *(Allows access to the Patient Portal for results and records)*

Primary Care Physician: _____ **Phone:** _____

Address:

THIS SECTION SHOULD ONLY BE COMPLETED IF THE PATIENT IS NOT THE SUBSCRIBER OF THEIR INSURANCE:

Pharmacy Name/Address: _____

Insurance Policy Holder Name:

Policy Holder DOB: Relationship to Policy Holder:

Emergency Contact Name: _____

Relationship: _____ **Contact Phone Number:** _____

ACKNOWLEDGEMENT OF NOTIFICATION OF PRIVACY PRACTICES**

I (Patient), _____ DOB:_____, acknowledge that I have been notified of this practice's privacy policy that includes medical and prescription history, and a written copy of this policy has been made available to me.

_____
Patient or Parent/Guardian Signature

_____
Date

Patient Financial Responsibility Form/Self-Pay Waiver

Thank you for choosing **IM | Health** for your medical needs. We are committed to providing you the highest quality healthcare, but we are not a collection agency.

Patient Financial Responsibilities

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care. **Please select ONE below:**

⬜ **Check here** if you agree to the **self-pay rate for services rendered, at time of service.**

- I voluntarily choose to receive treatment from this provider and agree to pay in full for all services rendered. I understand that I am personally responsible for all charges incurred and that payment is due at the time of service.
- I understand that the provider named above is not enrolled as a Medicaid provider and does not accept Medicaid as payment for services.
- I understand that Medicaid will not pay for any services I receive from this provider. I acknowledge that I cannot submit a claim to Medicaid for reimbursement.

⬜ **Check here** if you elect to use available medical insurance for visit coverage. You may be responsible for a copay or deductible per your insurance provider.

- We will bill your insurance for you, however the patient is required to provide the most correct and updated information regarding insurance.
- Copayments are due at the time of service.
- Patients are responsible for payment of copays, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan.
    - **You will NOT receive a bill. Your credit card on file will be charged, and a receipt published to your patient portal.**

WE ARE NOT A COLLECTION SERVICE.
You will be charged for any balance your insurance contract designates as your responsibility.

*Please note when choosing **either** of the above options; **A VALID CREDIT CARD ON FILE WILL BE REQUIRED PRIOR TO SERVICE.**

By my signature below, I hereby authorize assignment of financial benefits directly to **IM | Health** and any associated entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment. **I also accept the fees charged as a legal and lawful debt and agree to pay said fees, including any/all collection agency fees, if such be necessary.** I understand that **IM | Health** does not participate with any Medicaid/QMB products and that I will be responsible for any balances resulting from my care.

_____

_____

Patient Name **Date of Birth**

_____

_____

Patient or Parent/Guardian Signature **Date**

Patient Consent for Treatment and for Use and Disclosure of Protected Health Information

I authorize medical treatment as deemed necessary and appropriate by the medical providers of ***IM | Health Urgent Care*** and their employees participating in my care. This includes but is not limited to referral to a specialist or the Emergency Department for escalation of care.

With my consent, ***IM | Health*** may use and disclose Protected Health Information (PHI**)** about me to carry out treatment, payment, and healthcare operations. Please refer to the ***IM | Health*** Notice of Privacy Practices for a more complete description of such uses and disclosures. By signing this form, I acknowledge that I have been notified of this practice's privacy policy that includes medical and prescription history, and a written copy of this policy has been made available to me.

With my consent, ***IM | Health*** may call my home or other designated location and leave a message on voice mail in reference to any items that assist the practice in carrying out treatment, payment, or healthcare operations, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

With my consent, ***IM Health*** may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment or healthcare operations such as long as they are marked

With my consent, I authorize ***IM | Health*** to release medical information regarding the care and treatment I have received from this office to the physicians I have listed on the reverse side of this form.

I have the right to request that ***IM | Health*** restricts how it uses or discloses my **PHI** to carry out treatment, payment or healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I authorize payment of insurance benefits directly to ***IM | Health.*** I understand that I am fully responsible for any medical or surgical charge incurred in the course of my treatment, co-pay, deductible, all other charges determined to be patient responsibility or other type of unpaid service in excess of any hospitalization or health insurance that might be applicable.

I hereby authorize ***IM | Health*** to release pertinent information to my health insurance companies required in the course of my examination or treatment.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent***, IM | Health*** has the right to decline to provide treatment to me.

By signing this form, I am consenting ***IM | Health*** use and disclosure of my personal health information to carry out treatment, payment and healthcare operations.

By signing this form, I acknowledge that ***IM | Health*** uses third party laboratory services provided by LabCorp and HealthTrack Rx. I understand that sending a specimen to a lab not preferred by my health insurance plan or sending a test that is not covered by my health insurance plan could result in a bill that will be my responsibility to pay.

Printed Name of Patient: _____
DOB: _____

Patient OR Guardian Signature: _____ **Date:** _____

(ELECTIVE) CONSENT TO RELEASE MEDICAL INFORMATION

I, hereby authorize the disclosure of my protected health information (including but not limited to results, prescriptions, and appointment information) to the following person(s) listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____