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

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: ____

Pharmacy Name/Address: ____

Emergency Contact Name: ____

Relationship: ________________________ **Contact Phone Number:** ____________________________

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

Insurance Policy Holder Name: ____

Policy Holder DOB:________________________ **Relationship to Policy Holder:** ____________________

****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. We ask that you read, make the appropriate selection, and sign this form to acknowledge your understanding of our patient financial policies.

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.**

☐**Check here** if you elect to use available medical insurance for visit coverage. You may be responsible for a copay 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.
- Patients are responsible for payment of copays, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan.
- **Copayments are due at the time of service**.
- Coinsurance, deductibles and non-covered items are due after your insurance(s) have responded. Your credit card on file will be billed.
- Patients may incur, and are responsible for payment of additional charges, if applicable.

*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.**

______________________________ ______________

Patient Name **Date**

______________________________ ______________

Patient or Parent/Guardian Signature **Date of Birth**

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.

With my consent, ***IM | Health Urgent Care*** may use and disclose Protected Health Information (PHI**)** about me to carry out treatment, payment, and healthcare operations. Please refer to the ***IM | Health Urgent Care*** Notice of Privacy Practices for a more complete description of such uses and disclosures.

With my consent, ***IM | Health Urgent Care*** 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 Urgent Care*** 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 Urgent Care*** 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 Urgent Care*** 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 Urgent Care.*** 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 Urgent Care*** 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 Urgent Care*** has the right to decline to provide treatment to me.

By signing this form, I am consenting ***IM | Health Urgent Care's*** 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 Urgent Care*** exclusively sends lab specimens to LabCorp. I understand that sending a specimen to a lab not authorized by my health insurance plan could result in an unexpected bill that will be my responsibility to pay.

Printed Name of Patient: ____ **Date:** __________________

Patient <u>OR</u> Guardian Signature: ______________________________________ **DOB:** __________________

(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: ________________________