Complete this Quick Registration Area if you have registered here before.
If any information has changed since your last visit, please make changes below.

Patient Name: First _____ Last _____ DOB_____

PREMIER URGENT CARE

NEW PATIENT REGISTRATION

ARE YOU HERE FOR A WORK RELATED ILLNESS OR INJURY? ❑ YES ❑ NO

Where did you hear about Premier Urgent Care?

❑ Friend ❑ Mailer ❑ Newspaper ❑ Phone book ❑ Internet ❑ Radio
❑ Relative ❑ Physician ❑ Television ❑ Signage ❑ Work ❑Other_____

Pharmacy: _____ **Location:** _____

Patient Name: First _____ Last _____M.I. _____

Social Security Number: _____ DOB: _____

Address: _____City _____ State _____Zip_____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Marital Status: ❑ Child ❑ Single ❑ Married ❑Separated ❑ Divorced ❑ Widowed

Gender: ❑ Male ❑ Female Race: _____ Hispanic or Latino: ❑ Yes ❑ No

Primary Care Physician: _____ Date of Last Visit: _____

Were you sent here from CENLA URGENT CARE? ❑ YES ❑ NO

Email Address: _____

A survey will be sent via email to rate your experience during today's visit.

Would you like your discharge papers emailed to you? ❑ YES ❑ NO

Would you like access to our patient portal online? ❑ YES ❑ NO

If you had not heard about us, where would you have most likely gone to be treated?
❑ Primary Care Doctor ❑ Emergency Room ❑ Another Urgent Care ❑ Not Been Seen

Insurance Name: _____ Policy #_____ Are you the policy holder? ❑ Yes ❑ No

If you are not the primary insurance holder please complete the following to ensure proper billing:

Policy Holder Name:
First _____ Last _____DOB _____ SSN _____

Address _____ City _____ State _____ Zip _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

*********** *AUTHORIZED PERSONNEL ONLY* **********

Primary Insurance Verification Source: _____ **Secondary:** _____

Copay $_____ Debt Collected: ❑ Yes ❑ No Amount Collected $ _____ Initial _____

Was management contacted for any further authorization? ❑ Yes ❑ No Manager Name _____

PATIENT CONSENT FORM

I, the undersigned, hereby consent to the following treatment:

- Administration and performance of all treatments.
- Administration of any needed anesthetics.
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient.
- Use of prescribed medication.
- Performance of diagnostic procedures, tests, and/or cultures.
- Performance of other medically accepted laboratory test that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designee.

I fully understand that this is given in advance of any specific DIAGNOSIS, PROGNOSIS, MEDICATION, or treatment.

I understand that I am fully responsible for any additional charges for laboratory testing not performed at Premier Urgent Care.

I intend this consent to be continuing in nature even after a specific diagnosis or treatment.

I understand that Premier Urgent Care may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that Premier Urgent Care will use and disclose my information for the purposes of treatment, payment and healthcare options.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims; I assign the benefits payable for services to Premier Urgent Care.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

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

PATIENT RECEIPT OF HIPAA PRIVACY NOTICE

Dear Patient,

Premier Urgent Care is committed to maintaining the integrity of your protected health information and complies with all applicable state and federal regulations.

The federal privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA) have taken effect April 14, 2003. In support of our policy of complying with all applicable regulations, Premier Urgent Care provides patients with the HIPAA Notice of Privacy Rights.

While not required in order to receive treatment at Premier Urgent Care, we are obligated under federal regulations to ask that you sign an acknowledgment of the HIPAA Privacy Notice being made available to you.

Thank you,

Receipt of HIPAA Privacy Notice

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

_____ _____

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

*******PRINTED OR ELECTRONIC COPIES OF HIPAA PRIVACY NOTICE ARE AVAILABLE UPON REQUEST*******