PT #_____

EXPRESSMD URGENT CARE

# Patient Registration Form

**Section 1. General Information** – *NOTE: STUDENTS – PLEASE ONLY INCLUDE PERMANENT ADDRESS BELOW.*

**Patient Last Name:** _____ Patient **First Name:** _____ Middle **Initial:** _____
**Gender:** ____ **M /** ____ **F** **Date of Birth:** _____ **Social Security:** _____
**Address:** _____ **Apt/Lot/Unit #:** _____
**City:** _____ **State:** _____ **Zip:** _____
**Home Phone:** _____ **Cell Phone:** _____ **Email:** _____ (No Spam)
**Emergency Contact:** _____ **Relationship:** _____ **Phone:** _____

## Section 2. Insurance Information
(Card Holder Information)

### PRIMARY INSURANCE
☐ Check this box if information is same as above.
**Insurance Card Holder Name:** _____
____ **M /** ____ **F** **Holder's Date of Birth:** _____
**Holder's Address:** _____
**City:** _____ **State:** _____ **Zip Code:** _____
**Holder's SSN:** _____ **Phone:** _____
**Relationship to Patient:** ____ Parent / ____ Spouse

### SECONDARY INSURANCE
☐ Check this box if information is same as above.
Leave this section blank if no secondary insurance exists.
**Insurance Card Holder Name:** _____
____ **M /** ____ **F** **Holder's Date of Birth:** _____
**Holder's Address:** _____
**City:** _____ **State:** _____ **Zip Code:** _____
**Holder's Social Security:** _____
**Relationship to Patient:** ____ Parent / ____ Spouse

## Section 3. Guarantor Information
(Needs to be filled out if the patient is **under 18** or a **dependent**)

☐ Check this box if guarantor is the same as insurance holder.
**Last Name:** _____ **First Name:** _____
____ **M /** ____ **F** **Date of Birth:** _____
**Address:** _____
**City:** _____ **State:** _____ **Zip Code:** _____
**SSN:** _____ **Phone:** _____
**Relationship to Patient:** _____

## Section 4. Where did you hear about Express MD?

__ Signage __ Relative __ Friend __ Google Ad __ Work __ Internet
__Doctor Ref __ Billboard __ Phone Book __Letter __ Comm. Impact
__ Mailer __ Newspaper __ Existing Patient
__ Other _____

## Section 5. Race & Ethnicity

**Race:** ___ American Indian/Alaskan ___ Asian ___ Black/African Amer.
___ Native Hawaiian/Pacific Islander ___ White ___ Decline Ans.
**Ethnicity:** ___ Hispanic/Latino ___ Not Hispanic/Latino ___ Decline Ans.

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES—**I understand that the details of my rights and how my medical information will be used and disclosed by Express MD Urgent Care is set forth in the NOTICE OF PRIVACY PRACTICES and that a copy may be given to me upon request/is posted in the clinic. If I have a deductible with my insurance that has not been met, co-insurance that has not been collected, or different co-pay than what is listed on my card, I may get a bill in the mail for the amount that my insurance determines that I owe. I understand that at the time of my service Express MD cannot determine if I will owe any further amount and that amount is determined solely by my insurer. I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered. **I have completed the above and certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my insurance status or any of the above information.** I authorize the release of medical information to the health plan indicated for information requested by the health plan to determine the payment of medical benefits. The information authorized for release may include information about communicable or non-communicable disease, mental health, and substance or alcohol abuse. I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES.

**SIGNATURE OF PATIENT:** (IF PATIENT IS A MINOR, SIGNATURE OF PARENT OR LEGAL GUARDIAN) _____ **DATE:** _____

OFFICE USE ONLY: I have copied ☐ Government Issued ID - ☐ Insurance Cards - ☐ Verified the above information is completely filled out ● Initials:_____

1616 FM 685 Suite 106
Pflugerville TX, 78660
P 512-252-9094
F 512-252-9095
frontdesk@expressmdcare.com

- **Consent for Medical Treatment:** I give permission to ExpressMD Urgent Care to perform the following services that the physicians and other non-physician providers and assistants may deem to be necessary: (a) medical, surgical and diagnostic (e.g.: including, but not limited to, x-rays, blood draws, and laboratory tests) processes, treatments, and procedures; (b) administration of injections, medications, and immunizations ( with immunizations to occur after my receipt of any applicable vaccine information statements ("VIS" or "VISs")); and (c) completion of medically appropriate tests for communicable and other diseases.

  **Signature:** _____ **Date:** _____

- **Financial Responsibility:** ExpressMD Urgent Care will submit claims to my insurance carrier as well as medical records needed to evaluate the claims for payment. I further assign payment to benefits, otherwise payable to me, to be made payable to ExpressMD Urgent Care.

- **Financial Policy:** Unless you are here for employer paid services, you will be responsible for either full payment or payment as indicated by your insurance plan, If ExpressMD has a contract with your insurance company we will file today's charges with that insurance company. You will be responsible for your co-payment and or deductible, and the cost of any services not covered by insurance. You may receive a bill from ExpressMD for any unpaid balances.

  - If your treatment requires more complex evaluations, lab tests, vaccines, medications, x-rays, or supplies, you will be charged for those in addition to the appropriate office visit fee. These fees will be collected after service and treatment have been provided.
  - I understand that I am financially responsible for all charges not covered by my insurance. **Initials** _____
  - If you do not have insurance coverage or ExpressMD does not have a direct contract with your insurance company, you will be required to pay in full for your visit today. You can expect to pay and initial payment for medical care/treatment based on posted pricing in the center. This will be collected at check-in.
  - I do not have insurance and I acknowledge that I am responsible for all costs. **Initials** _____

- Due to billing purposes **ONLY**, we will require social security numbers for all types of visits. Failure to provide your social security number may result in either the insurance carrier or employer to refuse payment for your visit which will then become your responsibility in full. **Initials** _____

- **Primary Care Physician: (If you choose)**
  Name: _____ Location: _____
  Phone Number: _____ Fax Number: _____
  **( ) Decline**

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_____ _____

*Signature of Patient **or** Guardian* *Date*

☐ Check here if patient declined to sign or was unable to sign acknowledgement.

Staff Initials _____