ChoiceOne URGENT CARE
Your Choice for a Better Healthcare Experience

Patient Registration Form

Please fill-out completely. See the back page of this form for Notice of Privacy Practices.

Patient Information

Social Security #: _____

First Name: _____

Last Name: _____

Date of Birth: _____

Sex: ☐ Female ☐ Male

Street Address/Apt#: _____

_____

City: _____ State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Marital Status: ☐ Child ☐ Divorced ☐Married
☐ Separated ☐ Single ☐ Unknown ☐ Widowed

Employer Name: _____

Employer Phone: _____

____ Please Initial. I hereby acknowledge that I understand and have read the Notice of Patient Rights and Responsibilities which is located on the clipboard.

Additional Information

Primary Care Provider: _____

Preferred Pharmacy: _____

How did you hear about us?
☐ Referring Provider: _____
☐ Referring School: _____
☐ Other: _____

Emergency Contact: _____

Emergency Phone: _____

Relationship to Patient: _____

Was this the result of a motor vehicle accident?: ☐ Y ☐ N

Is this a work related injury?: ☐ Y ☐ N

Based on government regulations we are required to ask the following information:
Preferred language: _____
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Prefer not to answer
Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Prefer not to answer

REASON FOR VISIT:

COMPLETE THIS SECTION ONLY IF PATIENT IS UNDER 18 AND *NOT* SEEKING TREATMENT RELATED TO PREGNANCY OR SEXUALLY TRANSMITTED INFECTIONS (STIs):
Parent /Guardian Name: _____ **Employer:** _____

Insurance Information

INSURANCE INFORMATION: Please provide a copy of your insurance card for our files:
Primary Insurance Company: _____
Policy Holder Name: _____ **Date of Birth:** _____ **Relationship:** _____

OFFICE POLICY ON PAYMENT: It is our policy to require payment of all office charges at the time they are rendered. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to authorize a credit card transaction on their and pay all costs charged by the collection company and reasonable attorney fees. Please note, we do not bill 3rd parties for your visit, for example: Personal Injury Protection Insurance, Lawyers, Labcorp, Quest Diagnostics or other parties. All billing and fees related to that service will be handled directly between the third party partner and the patient's insurance provider and not ChoiceOne Urgent Care.

CONSENT FOR TREATMENT: I voluntarily present for treatment and consent to my Provider at ChoiceOne and whomever they may designate as their patient care team to provide my care, including diagnostic test, therapeutic procedures, medication administration, and other procedures considered advisable for my diagnosis, treatment, and course of care.

I HAVE REVIEWED THE CHOICEONE NOTICE OF PRIVACY PRACTICES ON THE BACK OF THIS FORM AND HAVE READ THE TERMS AND CONDITIONS AND ACCEPT FINANCIAL RESPONSIBILITY IN FULL FOR THIS ACCOUNT.

SIGNATURE _____ **DATE**_____

Print Name _____

ChoiceOne NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***PLEASE REVIEW IT CAREFULLY.***

OUR PLEDGE REGARDING MEDICAL INFORMATION: The privacy of your medical information is important to us. We understand that your medical information is personal, and we are committed to protecting it. We create a record of the care and services you receive at our organization, and we need this record to provide you with quality care and to comply with certain legal requirements. This notice will describe the ways we may use and share this information.

INSURANCE POLICY: Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you, we will provide an itemized statement that you may send to your insurance company for payment. We will be happy to submit to most insurance carriers, if you have provided us with accurate policy information. You are responsible for all deductibles not covered by insurance. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility. We do not participate with any Medical Assistance policies. We do not bill insurance carriers for Travel Immunizations.

AUTHORIZATION TO RELEASE AND RECEIVE OF MEDICAL RECORDS: I authorize ChoiceOne Urgent Care to release and receive any medical information and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when ChoiceOne Urgent Care deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the information obtained by this authorization without a further authorization signed by me for release of the information.

USE AND DISCLOSURE:

- **Treatment**. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by our staff members.
- **Reminders/Notifications.** Our staff will use your health information to send you follow-up care, referral or appointment reminders. We may also send you information describing changes occurring at ChoiceOne Urgent Care such as, address changes, new locations or changes in business hours.
- **Treatment Information.** Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that may be of interest to you.
- **Payment.** We may use and disclose your medical information for payment purposes. We may need to give your health insurance plan information so that your health plan will pay us or repay you for services.
- **Healthcare Operations.** Your health information may be used as necessary to support the day-to-day activities and management of ChoiceOne. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs and getting accreditation, certificates, licenses and credentials we need to serve you.
- **Law Enforcement.** Your health information may be disclosed to law enforcement agencies, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.
- **Public Health Reporting.** Your health information may be disclosed to public health agencies as required by law.
- **Workers Compensation.** We may disclose health information to workers' compensation or other similar programs.
- **Other uses and disclosures require your authorization.** Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

INDIVIDUAL RIGHTS: You have certain rights under the federal privacy standards. These include: the right to request restrictions on the use and disclosure of your protected health information, the right to receive confidential communication regarding your medical condition and treatment, the right to inspect and copy your protected health information, the right to an accounting of how and to whom your protected health information has been disclosed, the right to receive a printed copy of this notice

ChoiceOne DUTIES: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

RIGHT TO REVISE PRIVACY POLICIES: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION: You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the receptionist or Privacy Official. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

COMMENTS & COMPLAINTS: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to this office attention: Privacy Official. If you believe that your privacy rights have been violated, you should bring the matter to our attention by sending a letter describing the cause of your concern to the address listed above. You will not be penalized or otherwise retaliated against for filing a complaint.

FOR ADDITIONAL INFORMATION: Please inquire at the reception desk for a copy of the ChoiceOne Urgent Care Privacy Standards. This notice is effective on or after 3/1/2015.