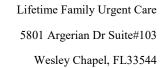


Lifetime Family Urgent Care
5801 Argerian Dr Suite#103
Wesley Chapel, FL33544

# New Patient Registration PLEASE PRINT

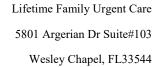
Last Name of Patient		First Na	me		MI	M	Age
						F	
			T				
Address			City		State	Zip	
Home Phone	Cell Phone		Date of Birth	Social S	ecurity.	No	
			Date of Birtin	Social S	ccurity	110.	
Your Email address:							
F	Responsible Part	y or Insu	rance Policy Hold	er			
Last Name		First Na	me		MI	Male	
						Fema	le
Address			City		State	Zip	
II Di	C 11 D1		D ( CD: 41	0 10	•,	N T	
Home Phone	Cell Phone		Date of Birth	Social S	ecurity	No.	
( )	Medical Insura	nce Com	  pany Information				
Name of Primary Insurance Comp		ince Com	Name of Policy H		 der		
Traine of Filmary insurance comp	, all y						
SS#	ID#			Group#			
				1			
Name of Secondary Insurance Con	Name of Secondary Insurance Company		Name of Policy Holder				
SS#	ID#			Group#			
Name of Drimony Come Physician				Phone			
Name of Primary Care Physician				/ Phone			
M	eaningful Use (re	equired h	v law): Please ci	rcle			
Race: American Indian or Alaska			nicity: Hispanic,	Language:	English	. Other.	
Native Hawaiian, or other Pacific	· · · · · · · · · · · · · · · · · · ·		Hispanic, Refuse		_	des Hindi and Thai	
African American, White, Hispan	ic, other race, oth	er to re	port	Spanish, Ru	ssian)		
Pacific Islander, Unreported/refus	e to report						
Who may we thank for referring y	ou to our office?	Phon	ne				
who may we thank for referring y	ou to our office.	(	)				
			,				
By signing below I hereby certify that the		is Date	•				
true and correct to the best of my knowle	edge and belief.			You will be r			
X				government i		noto ID a	it the
		-		time of service	J.G.		





### **Medical History**

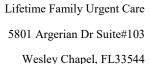
Date//		Age
Patient's Name		Date of Birth//
Form completed by	Relation (if other	r than patient)
Sex: □ Male □ Female	If female, are you pregnant? □ Yes □ No	Number or children
	ay?	
Current Medical History Are imposed take calcium, multivitamins, antacid?	munizations up to date? □ Yes □ No	Are you a smoker? □ Yes □ No
Do you drink alcohol? □ Yes □ No	Last colonoscopy// Last mammogram//	Last Dexa Scan// Last pap smear//
Do you use recreational drugs? □ Yes □ No	Last mammogram//	Last pap smear//
Current Medications	1	
Medication	Dosage	How often do you take
<b>Drug Allergies?</b> □ Yes □ No Describe:		
	r been hospitalized or had surgery? ☐ Yes ☐ No	
	1 0 7	
Have you ever had a serious medical problem? If yes, please list (e.g. high blood pressure, diab		
Family History Please list family medical history	ory (e.g. cancer, heart disease, anemia, diabetes etc	c)
Work History Occupation:	☐ Retired ☐ Disa	ıbled   Other
Are you:   Single   Marri	ied □ Partner □ Separated/Divo	orced   Widowed
Physician Comments:		
		REVIEWED BY
		REVIEWED BY





## **PATIENT QUESTIONNAIRE**

I.	•	ersons, if any, whom we may inform about your general cluding treatment, payment and health care operation):
II.	Can confidential messages (i.e., appointment telephone answering machine or voicema	
III.	Please print the telephone number where	
111.	appointment, lab and x-ray results, or other	
	than your home phone number:	
IV.	In case of emergency notify	
	Name:	Phone:
	Tume.	
PATII	ENT NAME	(guardian if under18 years)
PATII	ENT/GUARDIAN SIGNATURE	DATE
drawn of laborate authoris insuran Urgent informa	or collected that are not performed here will be sent to ory. I agree to be fully responsible for all charges in the Lifetime Family Urgent Care to release any an one purposes. I give my permission to send a copy of Care from any liability which may arise as a resul	elease of external prescription history. I understand that any lab specimens to an independent laboratory and will be billed separately by the independent including any legal fees and/or collection fees in the event of non-payment. It did all medical information in connection with services rendered for health medical records to my primary care physician. I also release Lifetime Family tof the use of information contained in the records listed. I certify that the crime to fill out this form with facts I know are false or to leave out facts I
	Payı	ment of Benefits
I author I agree paid by	ize payment of benefits by my insurance company d that after 60 days all balances due become my resp	r insurance if I have provided adequate information (ID and Insurance card). irectly to Lifetime Family Urgent Care for any medical and/surgical services. consibility regardless of insurance coverage. I also agree that all charges not y. The undersigned &/or patient shall remain responsible for all charges.
If no in	surance coverage full navment is required at time of	<b>Terms</b> of service. There will be a \$35.00 charge on any checks
	d by your bank.	1 service. There will be a \$55.00 charge on any cheeks
I certify	that the information I have furnished is true and correct.	I have read, understand and agree to the policies and terms above.
Printed ?	Name:	Date:
Signatur	e:	





#### PATIENT ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice to Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this consent

Patient Name (print):	
This Acknowledgement was signed by:	
	Patient Signature
Relationship to Patient (if other than patient):	
Date:/	
Witness Signature:	
	Practice Representative
Date:/	



#### **Lifetime Family and Urgent Care**

#### Financial Responsibility

This is an agreement between **Lifetime Family and Urgent Care, LLC**, a Florida corporation, as a creditor, and the Patient/Debtor named on this form

In this agreement the words "I", "You", "Your", and "Yours" mean the Patient/Debtor. The word "account" means any account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "our" refer to Lifetime Family and Urgent Care and/or its affiliated entities.

Insurance: Insurance is a contract between you and your insurance company. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. Although we may <u>estimate</u> what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. Please understand that insurance reimbursement can be delayed for multiple reasons. In fact, insurers will routinely stall, deny, and reduce payment. Insurers routinely process claims resulting in additional invoicing at no fault of Lifetime Family and Urgent Care, LLC. We will NOT under any circumstance falsify or change a diagnosis or symptom in order to convince an insurer to "pay" for care that is not covered, nor do we delete or change the content in the record that may prevent, or cause it to be considered covered.

## Please initial the following: We will estimate balances to the best of our ability. However, since these are estimates only, I understand that any remaining balances due to deductibles, co-insurance, and non-covered claims that are my responsibility to pay to Lifetime Family and Urgent Care. Your appointment may be rescheduled if your estimated amount due is not paid at check in. \_Missed Appointment Fee: I understand that Appointment Reminders are a courtesy. Failure to show up for, or cancelation of an appointment with less than 24 hours' notice may results in a now show fee of \$50 assessed to my account. The fee must be paid before a new appointment is scheduled. \_Administrative Charges: I understand that additional administrative charges may apply for items such as completion of medical forms, telephone consultations, and physician or provider letters. **Guarantee of Payment:** For value received, including but not limited to the services rendered, I agree to guarantee and promise to pay all charges and expenses incurred in my treatment, including those expenses not covered by any insurance policy presently in force, including co-payment and/or deductible. Unless specifically agreed in writing, all charges shall be paid at discharge or upon presentation of the first bill. I understand and agree that if Lifetime Family and Urgent Care is required to bring a claim or file an action to enforce this agreement, Lifetime Family and Urgent Care shall be entitled to recover from me its reasonable attorney's fees, expert fees, court costs, and any other costs of collection, in addition to the amount owed on your account.

Patient Signature: \_\_\_\_\_