Lifetime Family Urgent Care

5801 Argerian Dr Suite#103

Wesley Chapel, FL33544

New Patient Registration

PLEASE PRINT

Last Name of Patient	First Name	MI	M F	Age

Address	City	State	Zip

Home Phone ( )	Cell Phone ( )	Date of Birth	Social Security No.

Your Email address:	

Responsible Party or Insurance Policy Holder

Last Name	First Name	MI	Male Female

Address	City	State	Zip

Home Phone ( )	Cell Phone ( )	Date of Birth	Social Security No.

Medical Insurance Company Information

Name of Primary Insurance Company	Name of Policy Holder

SS#	ID#	Group#

Name of Secondary Insurance Company	Name of Policy Holder

SS#	ID#	Group#

Name of Primary Care Physician	Phone ( )

Meaningful Use (required by law): Please circle

Race: American Indian or Alaskan Native Asian, Native Hawaiian, or other Pacific Islander Black or African American, White, Hispanic, other race, other Pacific Islander, Unreported/refuse to report	**Ethnicity:** Hispanic, Non-Hispanic, Refuse to report	**Language:** English, Other, Indian (includes Hindi and Thai Spanish, Russian)
Who may we thank for referring you to our office?	Phone ( )	
By signing below I hereby certify that the above information is true and correct to the best of my knowledge and belief. X_____	Date:	You will be required to provide a government issued photo ID at the time of service.

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Medical History

Date ____/____/____ Age _____

Patient's Name _____ Date of Birth____/____/____

Form completed by _____ Relation (if other than patient) _____

Sex: □ Male □ Female If female, are you pregnant? □ Yes □ No Number or children _____

***** What medical concern brings you in today?** _____
_____
_____

Current Medical History Are immunizations up to date? □ Yes □ No Are you a smoker? □ Yes □ No
Do you take calcium, multivitamins, antacid? □ Yes □ No
Do you drink alcohol? □ Yes □ No Last colonoscopy ___/___/___ Last Dexa Scan ___/___/___
Do you use recreational drugs? □ Yes □ No Last mammogram ___/___/___ Last pap smear ___/___/___

Current Medications

Medication	Dosage	How often do you take

Drug Allergies? □ Yes □ No Describe: _____

What is your pharmacy name & number? _____

Past Medical History Have you ever been hospitalized or had surgery? □ Yes □ No

If yes, please list reason or surgeries _____

Have you ever had a serious medical problem? □ Yes □ No
If yes, please list (e.g. high blood pressure, diabetes, high cholesterol etc…)
_____
_____

Family History Please list family medical history (e.g. cancer, heart disease, anemia, diabetes etc…)
_____
_____

Work History Occupation: _____ □ Retired □ Disabled □ Other _____

Are you: □ Single □ Married □ Partner □ Separated/Divorced □ Widowed

Physician Comments:
_____
_____
_____
_____ **REVIEWED BY** _____

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PATIENT QUESTIONNAIRE

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation):

_____

_____

II. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail? YES_____ NO_____

III. Please print the telephone number where you want to receive calls about your appointment, lab and x-ray results, or other health care information if other than your home phone number: _____

IV. In case of emergency notify
Name:_____ Phone:_____

PATIENT NAME_____ (guardian if under18 years)

_____ _____
PATIENT/GUARDIAN SIGNATURE DATE

Authorizations

I authorize and consent to medical care and/or minor surgical care deemed advisable by the doctor on duty at the time of my visit in order to diagnose and provide treatment. I authorize the release of external prescription history. I understand that any lab specimens drawn or collected that are not performed here will be sent to an independent laboratory and will be billed separately by the independent laboratory. I agree to be fully responsible for all charges including any legal fees and/or collection fees in the event of non-payment. I authorize Lifetime Family Urgent Care to release any and all medical information in connection with services rendered for health insurance purposes. I give my permission to send a copy of medical records to my primary care physician. I also release Lifetime Family Urgent Care from any liability which may arise as a result of the use of information contained in the records listed. I certify that the information I furnish is true and correct. I know that it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

Payment of Benefits

I understand that Lifetime Family Urgent Care will bill my insurance if I have provided adequate information (ID and Insurance card). I authorize payment of benefits by my insurance company directly to Lifetime Family Urgent Care for any medical and/surgical services. I agree that after 60 days all balances due become my responsibility regardless of insurance coverage. I also agree that all charges not paid by my insurance company will be my responsibility. The undersigned &/or patient shall remain responsible for all charges, applicable co-payments and deductibles.

Terms

If no insurance coverage, full payment is required at time of service. There will be a $35.00 charge on any checks returned by your bank.

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: _____

Signature: _____

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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

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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 **estimate** 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: _____ Date: _____