midwest
CONVENIENT CARE

When You Just Can't Wait To Feel Better

PATIENT INFORMATION

NAME: DATE OF BIRTH:

ADDRESS: MARITAL STATUS:

CITY: STATE: ZIP: STUDENT STATUS:

SSN: GENDER AT BIRTH: GRADE:

HOME PHONE: CELL PHONE:

MEDICATION ALLERGIES:

PHARMACY OF CHOICE AND LOCATION:

PRIMARY DOCTOR:

CURRENTLY PREGNANT: YES OR NO CURRENTLY BREASTFEEDING: YES OR NO

TODAY'S SYMPTOMS:

RESPONSIBLE PARTY

NAME: DATE OF BIRTH:

ADDRESS: MARITAL STATUS:

CITY: STATE: ZIP: SSN:

HOME PHONE: GENDER: EMPLOYER:

CELL PHONE: WORK PHONE:

EMERGENCY CONTACT

NAME: RELATIONSHIP: PHONE:

NAME: RELATIONSHIP: PHONE:

I HEREBY AUTHORIZE RELEASE OF INFORMATION NECESSARY FOR MY INSURANCE COMPANY TO PROCESS MY CLAIM. THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO MIDWEST HEALTH GROUP CONVENIENT CARE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT PAID IN A TIMELY MANNER BY MY INSURANCE.

AUTHORIZATION

SIGNED: DATE:

620 Maple Valley Drive
Farmington, Mo 63640
(573) 454-2466
Fax (573) 454-2544

midwest
CONVENIENT CARE
When You Just Can't Wait To Feel Better

55 Nesbit Drive
Bonne Terre, Mo 63628
(573) 358-1700
Fax (573) 358-1702

Midwest Health Group Convenient Care, LLC

MWCC FINANCIAL POLICY

We are dedicated to providing the best possible care for you and we want you to completely understand our financial policies.

1. Payment is due at the time of service. We do accept Visa, MasterCard, Discover and Care Credit.
2. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a copayment at the time of your visit.
3. Not all insurance plans cover all services. In the event that your insurance plan determines a service to be "not covered" you will be responsible for the complete charge. Payment is due upon receipt of statement from our office.
4. Statements are sent out every 30 days. You will receive a total of three statements and if payment is not received at that time the account will be turned over to our collection agency.

I have read and understand the financial policy for Midwest Health Group Convenient Care, and I agree to be bound by its terms. I also understand and agree that Midwest Health Group Convenient Care may amend such terms from time to time.

X_____ _____

Signature of Patient or Responsible Party **Date**

X_____

Printed Name of Patient

FLAT RATE PRICING AGREEMENT/SELF PAY

I _____ do not have insurance, or I do not wish to have Midwest Health Group Convenient Care, file insurance for me. Our Private Pay pricing is $90.00 for a New Patient and $60.00 for an Established Patient. This amount along with any other testing, xrays, injections or office procedure will be due at the time of service.

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X_____

Print Name **Signature of Patient or Responsible Party**

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I AUTHORIZE THE FOLLOWING PERSONS TO HAVE ACCESS TO MY RECORDS PER HIPAA:

Name	Relationship	Home or Cell or Work Phone
Name	Relationship	Home or Cell or Work Phone
Name	Relationship	Home or Cell or Work Phone

I_____Authorize_____Do Not Authorize Midwest Health Group Convenient Care to leave messages on my home/cell phone regarding appointments, payments, and/or billing.

Would you like a copy of our Medical Records Privacy Policy? Yes_____ No_____

Signature:_____ **Date:**_____

AUTHORIZATION FOR TREATMENT OF A MINOR

Patient's Name: _____
Date of Birth:_____

I _____authorize Midwest Convenient Care to allow treatment of my minor child, by the following:

- Name: _____Relationship:_____Phone:_____
- Name: _____Relationship:_____Phone:_____
- Name: _____Relationship:_____Phone:_____
- Name: _____Relationship:_____Phone:_____

Signature of Parent/Guardian:_____**Date:**_____