PRECISION URGENT CARE

210 Old Country Road, Mineola, New York 11501 Phone: 516-279-4400 1-844-URG-DOCS email: contact@puc.com

PLEASE BE ADVISED THAT YOUR
URGENT CARE OR SPECIALIST
COPAY WILL BE TAKEN FOR THIS VISIT

Name of Patient: _____ ◯Male ◯Female

Address: _____

City/Town: _____ State: _____ Zip Code: _____

Date of birth: _____ Social Security number: _____

Telephone number: _____ ◯home ◯cell

Secondary number: _____ ◯home ◯cell

E-mail address: _____

Employer's name: _____

Employer's address: _____

Closest relative (name & phone number): _____

Relationship to the closest relative: _____

Primary doctor (name & phone number): _____

Pharmacy (name, street, town): _____

Type of insurance: ☐Medical Insurance ☐Worker's Compensation ☐No Fault

Primary insurance name: _____

Primary insurance subscriber: _____

Primary insurance subscriber date of birth: _____

Relationship to the insured: ◯spouse ◯child ◯other _____

Secondary insurance name (if applicable): _____

Secondary insurance subscriber: _____

Secondary insurance subscriber date of birth: _____

How did you hear about Precision Urgent Care? ☐ Friends/Family ☐ Drove by ☐ Mailing

☐Employer ☐ Google Search ☐Facebook ☐Internet ☐ Other (Specify) _____

OFFICE USE ONLY	Initials	Eligibility Date	Checked

Patient HIPAA Awareness

As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the U.S. Department of Health and Human Services Office for Civil Rights, we are not permitted to release patient information except as stated in the Notice of Privacy Practice, or in accordance with your wishes as stated below.

This waiver authorizes Precision Urgent Care to send/give medical information as noted:

Patient Name (First) _____ (Last) _____ (PLEASE PRINT)

Leave a voice mail recording including my Personal Health Information on my home/cell phone: ○ YES ○ NO

Leave a voice mail recording including my Personal Health Information on my business phone: ○ YES ○ NO

I authorize Precision Urgent Care to email me my Personal Health and Billing Information: ○ YES ○ NO

Email Address: _____

I authorize Precision Urgent Care to check my medication history: ○ YES ○ NO

Permit the individual stated below (Personal Representative) to receive prescriptions and/or test results: ○ YES ○ NO

Speak to a family member of my choosing (Personal Representative) regarding my Personal Health and Billing Information: ○ YES ○ NO

Name of Personal Representative: _____

On this date _____, I received / reviewed Precision Urgent Care's Notice of Privacy Practices, which describe how my medical information may be used and disclosed and explains how I can get access to this information.

The authorizations made above will remain effective until such time as I notify Precision Urgent Care in writing, by certified mail, of requested changes.

_____ _____

Signature of Patient or Legal Guardian | Patient's Name

_____ _____

Print Name of Patient or Legal Guardian | Today's Date

Patient Responsibility Disclosure Statement

Your signature below forms a binding agreement between Precision Urgent Care (the provider of medical services) and the Patient who is receiving medical services, or the Responsible Party for minor patients (those patients under 18 years of age). The Responsible Party is the individual who is financially responsible for payment of medical bills.

All charges for services rendered are due and payable at the time of service.

(*Please initial all below*)

____ I am responsible and expected to pay Precision Urgent Care for the following:

1. Any co-payment as set by my insurance carrier
2. Any unsatisfied deductible or termination of coverage
3. Any amount my insurance carrier deems my responsibility
4. Any amount considered non-covered by my insurance carrier

____ Co-Pays: All co-pays are due at the time of service. If your insurance requires any additional co-pays you will be responsible for payment and will be billed for it.
As we are an Urgent Care facility, the urgent care co-pay will apply. If no urgent care co-pay is listed on your card; we will charge you the specialist co-pay. If your UC co-pay is different than the specialist co-pay, you will be billed or refunded the difference.

____ Authorization to pay benefits to the physician: Any and all insurance checks that may go directly to the patient MUST be signed over to Precision Urgent Care for payment for services rendered. Failure to do this will result in the patient receiving a bill for services.
I hereby authorize payment for medical services provided directly to Precision Urgent Care physician. If I should receive any insurance payments I am to sign the check over to Precision Urgent Care.

____ Returned Check Policy: If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $12.00 Service Charge.

____ Durable Medical Equipment: As we are an URGENT CARE facility, we have urgent care contracts with most major health insurance companies. In abiding with our contract guidelines, we CANNOT bill insurance companies for DME (Durable Medical Equipment) such as crutches, slings, braces, and extremity immobilizers. We carry these products as a convenience and they are available to our patients as an out-of-pocket expense. By initialing, you acknowledge your understanding that any DME supplies cannot and will not be submitted to your insurance company by you or Precision Urgent Care for reimbursement.

____ To Obtain Payment for Treatment: We may use and disclose your PHI (Protected Health Information) in order to bill and collect payment for the treatment and services provided to you. We reserve the right to disclose your information to our business associates such as billing companies, claim processing companies, collection agencies, and other that process our healthcare claims.

I also understand that I will be responsible for any charges incurred by not providing the most current, correct insurance information to Precision Urgent Care.

Patient Name: _____ Date: _____

Signature of Patient / Guardian: _____