INFOCUS® URGENT CARE

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# New Patient Packet

**Please present your insurance card at time of check-in.**
**Settlement of patient financial responsibility is expected at time of service.**

**TYPE OF VISIT:** [ ] Insurance (present card at check-in) [ ] Self-Pay (payment due today after visit)
[ ] Work-Related Injury [ ] MVA [ ] Other: _____

## PATIENT DEMOGRAPHIC INFORMATION

Last Name: _____ First Name: _____ MI: _____
Date of Birth: _____/_____/_____ SSN: _____ Sex: _____
Address: _____ Home Phone: _____ [ ] Preferred
_____ Cell Phone: _____ [ ] Preferred
_____ Email: _____ [ ] Preferred

Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Separated [ ] Divorced

Emergency Contact: _____ _____ _____
Name Relationship Phone Number

## GUARANTOR INFORMATION

Please complete with information of person financially responsible for patient [ ] **Same as pt**

Last Name: _____ First Name: _____
Address: _____ Home Phone: _____ [ ] Preferred
_____ Cell Phone: _____ [ ] Preferred
_____ Email: _____ [ ] Preferred

## INSURANCE INFORMATION

Insurance Carrier: _____ Subscriber Name: _____
Member ID: _____ Patient Relationship to Subscriber: _____

**If this is a work- or auto-related injury, please fill out the Worker's Comp/Auto Insurance information:**

Carrier: _____ Subscriber ID/Policy #: _____
Employer (if WC): _____ Claim #: _____
Date of Injury/Accident: ____/____/_____ Adjuster Name, Phone #: _____

## PRIMARY CARE PHYSICIAN, PHARMACY

[ ] I authorize InFocus to fax my medical records to my PCP

PCP Name: _____ Phone Number: _____

Preferred Pharmacy: _____ Address: _____

## MEDICAL HISTORY

## Medical Release Form and Consent for Treatment

By signing below you are giving permission to our facility, InFocus Urgent Care, to share your medical information to anyone you list below. We will be sharing any and all medical information and treatment to anyone that you list.

| Person to Send Information Upon Request | Relationship to You |
|---|---|
| _____ | _____ |
| _____ | _____ |

**Patient/Guardian Signature:** _____ **Date:** _____/_____/_____

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## Authorization and Release for Charges and Treatment

Authorization for Treatment: I voluntarily consent to the administration and cost of medical and surgical procedures, X-ray, and medication for myself and my dependents.

Assignment of Insurance Benefits: I authorize payment directly to InFocus Urgent Care for all benefits and the release of medical information for all services and payments otherwise payable to me.

Guarantee of Payment: I understand that I am financially responsible and agree to pay all charges that are not or will not be paid by my insurance or third party payer. I understand that I must pay in full on the date of service any amount my insurance company identifies or will identify as my responsibility. I understand that if my insurance denies my claim or if I do not have insurance, I will pay in full for all services. I understand that if an invoice is mailed to me, payment is due within 14 days of receipt of said invoice.

Late Fees/Checks: A late fee will be added at $10 per month for all invoices over 30 days from the date of the invoice. $30.00 will be added to checks for insufficient funds.

Release of Records: I authorize InFocus Urgent Care to release, verbally or in writing, confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to work, or other health care operations, which may be utilization review, transfer and follow-up purposes.

Privacy Practice Receipt: I acknowledge I have read and understand the InFocus Urgent Care Notice of Privacy Practices.

**Patient/Guardian Signature:** _____ **Date:** _____/_____/_____
Patient/Authorized Representative

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## Credit Card Authorization Policy

At InFocus Urgent Care, we require a credit or debit card on file as a convenient method of payment for any patient responsibility amounts **only** after a claim has been filed, processed, and correctly adjudicated by your insurer. Our office will contact the cardholder prior to any charges.

**I authorize InFocus Urgent Care to charge the portion of my bill that is my financial responsibility to the following credit or debit card:**

**☐Amex ☐Visa ☐MasterCard ☐Discover**

**Credit Card Number** _____

**Expiration Date** _____/_____

**Cardholder Name** _____

**Billing Address** _____

_____

I (we), the undersigned, authorize InFocus Urgent Care to charge the above credit card for services rendered within 30 days of adjudication for balances that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance for services InFocus Urgent Care provides me.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 14-day notice to InFocus Urgent Care and the account must have no outstanding balance.

**Patient/Guarantor Name (Print):** _____

**Patient/Guarantor Signature:** **X**_____ **Date:** _____/_____/_____