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 at time of 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 patient**

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

INSURANCE INFORMATION

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

PRIMARY CARE PHYSICIAN, PHARMACY

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

PCP Name: _____ Phone Number: _____

Preferred Pharmacy: _____ Pharmacy Address: _____

MEDICAL HISTORY

List all medications and doses:	List all known allergies medication:
	List all current and previous medical conditions/surgeries:

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:** _____/_____/_____

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 (5%) per month for all invoices over 30 days from the date of the invoice. $30.00 will be added to checks returned 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

Credit Card Authorization Policy

At InFocus Urgent Care, we require a credit or debit card on file as a convenient method of payment or reimbursement 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 _____ **CVV:**_____

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:** _____/_____/_____

PATIENT ACKNOWLEDGEMENT

We will make every effort to secure payment for your visit from your health insurance provider, auto insurance, or employer's insurance when you have suffered a workplace injury. However, in the event that your insurance company, or the insurance company provided to us from your employer, denies payment of your claim, you will be billed for the medical services provided to you at InFocus Urgent Care.

By signing below, you agree to be financially responsible for the services you receive at InFocus Urgent Care. This means that in the event an insurance company denies payment to InFocus Urgent Care for services provided by InFocus, you agree to personally pay the amount owed. You agree to be responsible for any deductible, co-pay, or co-insurance regardless of whether you were notified about it at the time of your visit. If InFocus Urgent Care is notified after your visit that you are responsible for any amount, you agree to pay that amount within two weeks of being notified. Failure to pay any amount owed within two weeks may result in the charges being applied to your credit card of record. and

co-insurance amounts and that these charges can not be waived for any reason. (InFocus could lose its contract with an insurance company for waiving a co-pay, deductible, or co-insurance). Additionally, reimbursements of any kind can not be provided after a patient has received treatment unless the reimbursement is related to a clerical error.

Any amount owed to InFocus Urgent Care will be considered past due if payment has not been received within 30 days of notification of your outstanding balance. You will be charged a ten percent (10%) late fee if you have not paid your invoice within 30 days of notification. You will be charged an additional 10% late fee every thirty days thereafter. InFocus Urgent Care works with a collection agency to collect past due amounts. You agree to pay the cost of collections for any amount owed up to the maximum amount allowed by NJ laws. You understand that InFocus Urgent Care reports delinquent accounts to the major credit reporting agencies after 90 days of delinquency. We will always remove a report of delinquency upon payment of a debt.

InFocus charges a returned check fee of $50.00 in addition to the amount owed.

By signing below you agree to the aforementioned terms.

PATIENT NAME: _____ **DATE:** _____

PATIENT SIGNATURE: _____