URGENT CARE
american family care

9058 Old Lee Highway Ooltewah, TN 37363

Phone: 423-212-1808

Monday - Friday: 8:00 AM - 8:00 PM
Saturday & Sunday: 8:00 AM - 5:00 PM

Patient Registration Form

Please fill out form completely. See Notice of Privacy Practices.

STOP ***Is today's visit work related? If yes: Do not complete this form. Please see front desk staff for instructions.***

Patient's Full Name: _____ Social Security #: _____

Date of Birth: _____ Sex: ☐ M ☐ F **REASON FOR VISIT:** _____

Street Address /Apt #: _____

_____

City, State, Zip: _____ ***Was this the result of a motor vehicle accident?*** ☐ Yes ☐ No

Home Phone: _____ Leave message: ☐ Yes ☐ No How did you hear about us? _____

Local or Cell Phone: _____ Leave message: ☐ Yes ☐ No Home Email Address: _____

Work Phone: _____ Confidential Email Address: _____

Best form of contact? ☐ Home ☐ Cell ☐ Other Emergency Contact: _____

Primary Care Physician: _____ Emergency Contact Phone: _____

Primary Care Phone or City & State: _____ Relationship to Patient: _____

Based on government regulations we are required to ask the following information: ☐ *I prefer not to answer*

Preferred Language: _____ Race: ☐ American Indian or Alaska Native ☐ Asian

Ethnicity: ☐ Hispanic or Latino ☐ Black or African American ☐ Caucasian

☐ Non Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander

GUARANTOR INFORMATION

☐ *Check if same as patient information and sign at X below. If not, please complete entire section and sign.*

Name: _____ Sex: ☐ M ☐ F Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other

Date of Birth: _____ SSN#: _____ Guarantor Employer: _____

Street Address /Apt #: _____ Employer Phone: _____ Ext #: _____

City, State, Zip: _____

Home Phone: _____

Local or Cell Phone: _____ Email: _____

I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office is due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefits to this office. In the event that my account is turned over to a collection agency, I agree to pay all late fees, costs of collection fees, and/or attorney's fees and all court costs, if any.

X: _____ **DATE:** _____

Patient/Guarantor Signature

INSURANCE INFORMATION

Primary Insurance

Insurance Plan Name: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy ID: _____ Group Number: _____ Subscriber Name: _____

Subscriber Date of Birth: _____

Secondary Insurance *(if applicable)*

Insurance Plan Name: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy ID: _____ Group Number: _____ Subscriber Name: _____

Subscriber Date of Birth: _____

CONSENT FOR TREATMENT

I, the undersigned, consent to the care and treatment by the attending physician, his/her associates or assistants. I acknowledge that no guarantees have been made as to the effect of such treatment.

SIGNED: _____ **DATE:** _____

Patient/Guardian Signature (if patient is a minor)

I have reviewed the American Family Care Notice of Privacy Practices as provided at registration and understand that I may request a copy of the policy at any time.

SIGNED: _____ **DATE:** _____

Patient/Guardian Signature (if patient is a minor)

Patient Authorization to Release Medical Records/Disclose Protected Health Information

Patient Name_____

Patient Date of Birth_____/_____/_____ **Patient SSN** _____

Name of Individual Requesting Release_____

Relationship to Patient:
- ☐ Self
- ☐ Parent/Guardian of minor
- ☐ Legal Counsel – Provide copy of legal representation document
- ☐ Other – specify:

Purpose of the Release: At the Request of the Patient

I hereby authorize American Family Care to release any medical records and/or medical information to the following individual(s):

1. Name_____

   Address_____
2. Name_____

   Address_____
3. Name_____

   Address_____

I understand that, in compliance with Privacy Act regulations (45 CFR 164.508(c)),

- I request and authorize release of medical records and/or medical information to the above named party(s).
- This release is voluntary and I have the right to revoke this authorization at any time. My revocation must be in writing and provided to American Family Care.
- I may refuse to sign this authorization and such refusal will not affect my treatment.
- If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
- I have a right to inspect and receive a copy of my own protected health information.
- I have a right to a signed copy of this authorization.

This authorization shall expire on _____/_____/_____**.** If no date is provided, this authorization will expire one year from the date of signature/authorization indicated below.

_____ _____

Patient Signature **Date of Signature/Authorization**