COMPASS URGENT CARE®

Patient Registration Form

Last name: _____ First Name: _____ MI: _____

SSN: _____-____-_____ Birth Date: _____/_____/_____ Gender {circle} MALE FEMALE

Address: _____ City: _____ State: ____ Zip: _____

Cell Phone: (_____) _____-_____ ***Email:**_____@_____

Race: _____ Preferred Language: _____ Hispanic or Latino? Y/N

***Emergency Contact:** (First/Last Name) _____

Relationship: _____ Phone: (_____) _____-_____

***Pharmacy:** _____ ***Primary Physician:** _____

Primary Insurance: _____ Co-pay:_____

Insured Name: _____ Relationship: _____

Birth Date: _____/_____/_____ SSN: _____-_____-_____ Phone: (_____) _____-_____

Secondary Insurance: _____ Co-pay: _____

Insured Name: _____ Relationship: _____

Birth Date: _____/_____/_____ SSN: _____-_____-_____ Phone: (_____) _____-_____

*******Please list the person who will be responsible for any remaining bill*******

Guarantor Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Birth Date: _____/_____/_____ SSN: _____-_____-_____ Phone: (_____) _____-_____

Authorization to Discuss Medical information

I,_____ give authorization for Compass Urgent Care to disclose my records to the
(Patient's Name)

following person(s) or personnel:

Name:_____ Relationship: _____
Name:_____Relationship: _____

***Reason for Visit:** _____

PATIENT RECEIPT OF HIPAA PRIVACY NOTICE

Dear Patient,
Compass Providence Urgent Care is committed to maintaining the integrity of your protected health information and complies with all applicable state and federal regulations.

The federal privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA) have taken effect April 14, 2003. In support of our policy of complying with all applicable regulations, Compass Urgent Care provides patients with the HIPAA Notice of Privacy Rights.

While not required in order to receive treatment at Compass Urgent Care, we are obligated under federal regulations to ask that you sign an acknowledgement of the HIPAA Privacy Notice being made available to you.

Thank you.

Receipt of HIPAA Privacy Notice
I acknowledge receipt of the Notice of Privacy Rights with detailed information about how Compass Urgent Care may use and disclose my protected health information. I understand that Compass Urgent Care reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

_____
Printed Patient Name

_____ Date: _____
Signature of Patient or Parent/Guardian

Office Use Only: To be completed only when a patient declines to sign acknowledgement.

Check here if patient declined to sign acknowledgement _____

Staff Signature: _____ Date: _____

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INFORMED CONSENT

There are risks associated with injections ("shots"). While a bad reaction is rare, any of the following are possible.

- Pain, bruising, inflammation, and numbness at the injection site
- Injury to nerves, muscles or blood vessels at the injection site (temporary or permanent)
- A "flushing: or "hot flash" up to 24 hours after the injection, especially with steroid medication
- Allergic reaction to the medication
- Dizziness or fainting after the injection
- Skin discoloration or skin dimpling at the injection site
- Infection at the injection site

In the event that your Provider recommends an IV (inserting a sterile needle into your vein and injecting medication and/ or fluids), or taking blood for lab tests, any of the following are possible:

- Discomfort, bruising, and pain at the site of insertion
- Inflammation of the vein used
- Allergic reaction, from mild to severe, to the medications

You have the right to be informed of the procedure and of any alternative options. Except in emergencies, procedures are not performed until you have the opportunity to receive information regarding the procedure.

Should you receive an injection, our policy is that all patients must lay down on the patient table for at least 10 minutes.

I will inform the Doctor, Nurse Practitioner, Physician Assistant or other staff of Compass Urgent Care about all of my **allergies** and all of the **medication I take**.

My signature below means that:

- I understand the information provided on this form and agree
- I intend this consent to apply to my present and future injections ("shots") and intravenous (IV) treatments.

_____

Printed Patient Name

_____ Date: _____

Patient Signature

Refusal to sign acknowledgement does not prevent the patient from continuing to be treated

Patient Financial Responsibility Form/ Self-Pay Waiver

Thank you for choosing Compass Providence Urgent Care for your medical needs, we are committed to providing you the highest quality healthcare. We ask that you read, make the appropriate selection, and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care. **PLEASE CHECK ONE BELOW:**

- ☐ Check here if you agree to the **self-pay rate for services rendered, at time of service.**

- ☐ Check here if you elect to use available medical insurance for visit coverage. Self-pay rates **will not** apply after date of service.

  - We will bill your insurance for you; however, the patient is required to provide the most correct and updated information regarding insurance.
  - Patients are responsible for payment of co-pays, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan.
  - Copays are due at the time of service.
  - Coinsurance, deductibles, and non-covered items are due after your insurance(s) have responded.
  - Patients may incur, and are responsible for payment of additional charges, if applicable.

By my signature below, I hereby authorize assignment of financial benefits directly to Compass Providence Urgent Care and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Patient Name: _____ Date:_____

Patient/ Guardian Signature: _____

Patient Language Consent Form

You expressly consent and agree that, in order to discuss or service your account(s) (the "Accounts") or to collect amounts you may owe, Compass Urgent Care, and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith Billing Services may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that we may also contact you by sending text messages, emails, using any e-mail address you provided to us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts at any telephone number associated with the accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

Thank you,

Billing Services

Providence Location: 866-272-0376

Snow Road Location: 888-464-7207

Patient Name: _____ Date: _____

Patient Name/ Guardian Signature: _____

Depending on your insurance plan, there may be a portion of today's visit that is not covered. This unpaid portion will be your responsibility. Compass Urgent Care requires authorization to bill your credit or debit card for any unpaid portion of your visit. Within 30 days of your office visit, you will receive an email detailing what was paid by your insurance and what the remaining balance is on your account. The remaining balance is your responsibility. You will have 10 days from the date of the email to pay in full using cash, check, or credit card. Should payment arrangements not be made within those 10 days, your credit/debit card will be charged for the remaining balance on your account.

Compass Urgent Care requires a credit or debit card to cover any portion of your visit not covered by your insurance. Your credit/debit card information will not be stored on our computers, but will be held for 90 days by First Data – the largest credit card processor in the world.

You will be asked to sign this authorization and provide a credit/debit card at every visit.

Thank you for choosing Compass Urgent Care to guide you on your path to better health!

Credit Card/Debit Card Authorization

Compass Urgent Care submits claims to insurance carriers as a convenience to all our patients. At this time we request authorization to balance bill a major credit card or debit card to cover amounts determined by your insurance to be your responsibility.

Upon receipt of the explanation of benefits from your insurance carrier, any unpaid portion of your claim will be billed to your credit card or debit card. Should insurance pay in full, your account will not be charged.

All credit card/debit card information will remain absolutely confidential and securely stored by **First Data.** Compass Urgent Care will not store any banking account data.

I hereby authorize Compass Urgent Care to charge any and all outstanding balances, after insurance company reimbursement or denial, to my credit/debit card 10 days after the email is sent. I understand that I will not receive a statement if there is no balance due after processing my credit card for payment.

Valid Email: _____

_____ _____

Patient Name / Cardholder Signature Date

COMPASS URGENT CARE®

List of current RX	Dose	Intake Quantity	Condition associated with RX
example: Lisinopril	*40mg*	*1 x Daily*	*High Blood Pressure*

List of ALL allergies

List of Prior Surgeries

COMPASS URGENT CARE®

PLEASE HOLD ON TO THIS SHEET AND GIVE IT TO THE TRIAGE NURSE WHO WILL CALL YOU TO THE BACK