Patient Registration Form

PAYMENT DUE AT TIME OF SERVICE

Patient Name Last:	First:	Middle:
Date of Birth:	Social Security Number:	Sex: ☐M ☐F
Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed		
Mailing Address:		City, State, Zip
Home Phone: ☐ Preferred	Cell Phone: ☐ Preferred	Work Phone: ☐ Preferred
	Employer:	Occupation:

List approved people to discuss patient information

Name_____ Relationship_____

Name_____ Relationship_____

Emergency Contact: **Relationship:**

Phone Number:

How did you hear about us?

☐ Drive-by/signage ☐ Social Media ☐ Radio/TV ad

☐ Employer/Work ☐ Family/Friend ☐ Mailer ☐ Other _____

Parent or Guarantor's Name: (We do not see infants under the age of 6 months.)

Last:	First:	Middle:
Date of Birth:	Social Security Number:	Sex: ☐M ☐F
Street Address:		City, State, Zip
Home Phone:	Work Phone:	Employer:

Authorization and Release

Authorize for Treatment

Please initial

I voluntarily consent to the administration and cost of medical and surgical procedures, x-ray, and medications for myself and/or my dependents.

Medicare/Medicaid

Please initial

Due to overwhelming government regulations we **DO NOT** accept Medicare. We are happy to see both Medicare patients on a fee for service basis using our discounted cash pay prices. We ask all Medicare eligible patients (age 65 or older) to sign a Medicare opt-out agreement for private payment options with us.

Release of Records

Please initial

I authorize this urgent care center to release (verbal or in writing) confidential medical information to my primary care physician, medical facility or physicians referred to me by this urgent care center, including my insurance carrier, employer if treatment is related to employment purposes, or other health care operations which may be liable to me or my practitioner(s) for charges for this treatment and for quality management, utilization review, transfer, and follow-up purposes.

Receipt of Privacy Practices

Please initial

I acknowledge that I have received and read the Notice of Privacy Practices of this urgent care center.

Receipt of Email Privacy

Please initial

SATS requests your email to allow office communication and future patient access to medical records. I understand that SATS will never sell or rent my personal information to third parties for their use for any reason. I also understand that SATS will emply reasonable technical, administrative, and physical safeguards to protect the confidentiality and security of your personal information.

*My Email Address is: _____@_____

I understand that a copy of this agreement may be used with the same effectiveness as the original.

PATIENT SIGNATURE _____DATE _____ /_____ /_____

RESPONSIBLE PARTY_____DATE_____ /_____ /_____