KEYSTONE MEDICAL URGENT CARE

Patient Registration From

Thank you for choosing Keystone Medical & Urgent Care. Please complete all applicable fields below. This information will remain confidential.

Patient Information			
Patient Full Name:			Date: / /
Date of Birth: / /	SSN: - -	Gender: Female	Marital Status: Single
Address:		**Contact Phone Number(s):**	
City: State: Zip:		Home:	
Email Address:		Cell:	
Primary Care Physician:		PCP Phone:	
PCP Address:		City: State: Zip:	
Emergency Contact:		Emergency Contact Phone:	

Insurance Information *(Primary)*			
Name of Insurance:		Policy ID:	Group ID:
Insured's Full Name *(Primary Cardholder)*:		Relation: Other	
Date of Birth: / /	SSN: - -	Phone:	
Address:	City:	State:	Zip:

Insurance Information *(Secondary)*			
Name of Insurance:		Policy ID:	Group ID:
Insured's Full Name *(Primary Cardholder)*:		Relation: Other	
Date of Birth: / /	SSN: - -	Phone:	
Address:	City:	State:	Zip:

Responsible Party *(if applicable)*			
Responsible party full name:			DOB: / /
Address:		Relation: Other Other(*specify):*	
City: State: Zip:		Phone:	

Payment is required at the time that services are rendered unless you are a member of a participating insurance plan of Keystone Medical & Urgent Care, LLC. I authorize the release of information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. If Keystone Medical & Urgent Care bills my health insurance company on my behalf, I authorize payment to be paid directly to Keystone Medical & Urgent Care. Any co-payment and deductible will be collected at time of service.

I understand the terms of payment and I have been given the opportunity to read KMUC's Financial Policy. I understand and accept that I am ultimately responsible for payment of services rendered by KMUC if such services are not paid for by my insurance(s). I understand that a late charge of 1.5% per month may be applied to any unpaid patient balance that is not paid within 30 days from receipt of a bill. I understand that a charge of $50 is applied for any returned personal checks due to insufficient funds.

I authorize my information to be accessed by Keystone Medical & Urgent Care, LLC to provide continuity of care. This information includes, but is not limited to: diagnoses, prescriptions, treatment plans, lab results, referrals, and x-ray reports.

X: _____ Date: _____

Signature of Patient/Guardian

Click to Print Form

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Acknowledgement of Notice of Privacy Policy

I understand that this acknowledgement is not required to receive treatment at Keystone Medical Urgent Care. I acknowledge, under federal guidelines of the HIPAA Privacy Notice, that I have been given the opportunity to thoroughly read and have had any questions answered about the Notice of Privacy Practices at Keystone Medical Urgent Care. I acknowledge receipt of the Notice of Privacy Rights with detailed information regarding how Keystone Medical Urgent Care may use and disclose my protected health information. I understand that Keystone Medical Urgent Care reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

☐ I give permission for KMUC to leave a message with my health information via (check all that apply):

☐ Phone — List Preferred Number: _____

☐ Family Member — Household Member Name:_____

☐ Email

☐ I DO NOT give my permission for Keystone Medical UC to leave a message with my health information.

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

FOR OFFICE USE ONLY:

An effort has been made to obtain written acknowledgement of receipt of Keystone Medical Urgent Care's Notice of Privacy Practices.

Acknowledgement could not be obtained for the following reason(s):

☐ **Patient/Guardian refused to sign on this date: _____**

☐ **Communication/language barriers prohibited obtaining acknowledgement**

☐ **An emergency prohibited obtaining acknowledgement**

☐ **Other (explain) _____ Refusal to obtain acknowledgement does not prevent the patient from continuing to be treated at Keystone Medical Urgent Care.**

Employee Signature: _____ Date:_____

Authorization to Treat

I understand that this authorization is voluntary and I may refuse to provide authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I may inspect or copy the information to be used or disclosed, and that information used or disclosed to my primary care physician may be subject to disclosure by the primary care physician, and may no longer be protected by federal and state privacy regulations. I further understand that I may revoke this authorization at any time by providing written notification to the Health Information Management Department at **KMUC**. The revocation will not affect any actions taken before the receipt of the written revocation.

By signing this document, I, being the patient/legal guardian authorize **Keystone Medical Urgent Care** to provide medical care in accordance with currently accepted medical standards and guidelines.

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

Consent to Treat a Minor *(if applicable)*

I confirm that I am the parent or legal guardian of the above-referenced minor. I hereby authorize Keystone Medical Urgent Care to provide medical care as it so deems necessary to the minor. In the event that the minor has received treatment at Keystone Medical Urgent Care prior to the date of this form, I hereby authorize treatment in addition to the treatment(s) of a prior date.

X: _____ Date:_____

Signature of Patient/Guardian