HOAG URGENT CARE PATIENT REGISTRATION / INFORMATION SHEET

hoag
Urgent Care

Name: _____
LAST FIRST MIDDLE

Date of Birth: _____ Gender: ☐M ☐F Marital Status: _____
Email Address*: _____ Primary Language: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Primary Care Physician (PCP):_____

Phone Messages

Do you give Hoag Medical Group permission to leave a detailed message regarding your care, at one of the phone numbers provided above? *Please mark at that apply*

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ No, do not leave any messages regarding my care.

Contact Name: _____ Relationship: _____
Phone: _____

Release of Information

I hereby authorize and request release my health information (PHI) to:

1. Name _____ Relationship _____
2. Name _____ Relationship _____

Emergency Contact

Emergency Contact Name: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

Additional Patient Information

Ethnicity: ☐Hispanic/Latino ☐Non – Hispanic/Latino ☐Decline
Race: ☐White ☐Asian ☐Black/African American ☐ American Indian ☐Hawaiian/Pacific Islander ☐Two or more ☐Decline

*I hereby assign my insurance benefits to be made directly to my physician and any assisting physicians, for services rendered. I hereby attest that the INSURANCE INFORMATION PROVIDED is accurate and that I am an eligible member and understand that **I am responsible for knowing my benefits / coverage and tests ordered by my physician may NOT be covered**. I will be financially responsible for all charges that are not covered by my insurance company. I understand that I will be charged a 1% per month finance charge on all accounts over 90 days. I also hereby authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for the medical serviced and further treatment of care by another physician. By providing my email address, I am electing to receive email communication from Hoag Medical Group and its affiliates. I further agree that a photocopy of this agreement shall be as valid as the original. Payment is due at the time services are rendered. All charges are the direct responsibility of the patient. Hoag Medical Group cannot render services on the assumption that the charges will be paid by the Insurance Company. Insurance is an agreement between you and your insurance company. If Hoag Medical Group has problems collecting payment from you, we will also add attorney's fees, collection agency costs and any related fees to your bill.*

I hereby agree to give consent for treatment. I understand that Hoag Medical Group ("HMG") including Hoag entities, may share my health information for treatment, billing and healthcare operations. I understand that I may obtain a copy of the Notice of Privacy Practices that describes how my health information is used and shared, by visiting www.HoagMedicalGroup.com. I understand that HMG has the right to change this notice at any time.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that I am entitled to a copy of Hoag Medical Group's Notice of Privacy Practices. I can access a copy of the Notice of Privacy Practices from the Hoag Medical Group website or from the office directly. I understand that this authorization remains in effect until it is revoked by my request in writing.

Patient Signature: _____Date: _____

Patient Signature: _____ Date: _____