Patient Registration and Consent

Patient Information:

PT ACCOUNT #_____ **Date:_____**

Pharmacy & Location:_____(we e-scribe RX's)

SSN:_____ Female or Male (circle one)

Name:_____Nickname:_____

Date of Birth:_____

Primary Address:_____

City:_____State:_____Zip Code:_____

Primary Phone #:_____ Type: Home/Cell/Work (circle one)

*******may we leave a message in regards to your PHI?******* ***YES OR NO (Circle one)***

Email Address:_____

Gender Identity:_____

Ethnicity: (circle one) **Hispanic/Latino / Not Hispanic/Latino**

Race:(circle one) **American Indian-Alaska Native / Asian / Black-African American/ White /Other_____**

Emergency Contact:

Name:_____ Relationship:_____ Ph#:_____

Additional Patient Information:

Primary Care Physician:_____ Phone #:_____

Insurance Company:_____

Responsible Party/Guarantor:_____Relationship:_____

Phone#:_____

DO YOU HAVE A LIVING WILL? ***YES OR NO (Circle one)***

Patient Consent:

- I have been provided a Notice Of Patient Privacy Practices that provide a more complete description of Protected Health Information uses and disclosures.
- I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Total Care Plus Urgent Care and its associated providers, clinicians and other personnel. I understand that no guarantee has been or can be made as to the results of the treatments or examinations of Total Care Plus Urgent Care.
- I consent to the use and disclosure of my/the patient's Protected Health Information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the Notice of Patient Privacy Practices.
- I authorize payment of medical benefits directly to Total Care Plus Urgent Care or their designee for services rendered.
- I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

Patient(print name): _____

Patient/Authorized Person Signature: _____

Relationship: _____ ***Date:*** _____

Release of Information:

Total Care Plus reserves the right to communicate protected health information(PHI) with family or friends when it is deemed in the best interest of the patients as described in the Notice of Patient Privacy Practices. In order to have your PHI shared in other circumstances with members of your family or friends, please list those individuals below that we are authorized to release information to, and the type of information we can release.

*Name & Phone #:*_____*Relationship:*_____*Financial / Medical / Both*

*Name & Phone #:*_____*Relationship:*_____*Financial / Medical / Both*

*Name & Phone #:*_____*Relationship:*_____*Financial / Medical / Both*

Patient Acknowledgement: I understand I have the right to revoke authorization at anytime. I understand that a revocation is not in effect for cases where information has already been shared, but will be going forward. I understand that information used and disclosed as a result of this authorization may be subject to re-disclosure by the recipient, and may no longer be protected under federal law. I understand that I have the right to refuse to sign this authorization, and my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patent.

Patient(print name): _____

Patient/Authorized Person Signature: _____

Relationship: _____ ***Date:*** _____

Total Care

Patient Medical History:

Allergies List All (if you have a list we can make a copy for you)

_____

_____

Medications List All (if you have a list we can make a copy for you)

_____

_____

CONDITION	PERSONAL (X if yes)	MOM (X if yes)	DAD (X if yes)	CONDITION	PERSONAL (X if yes)	MOM (X if yes)	DAD (X if yes)
Anemia				High Cholesterol			
Arthritis				Kidney/Bladder			
Cancer				Liver/Hepatitis			
Depression/Anxiety				Seizures			
Diabetes				Stroke			
Eye Disorder				Thyroid			
Headaches				Ulcers			
Heart Disease				Blood clots			
Heartburn				Alzheimer's/Dementia			
High Blood Pressure				Asthma/COPD			

Have you had surgeries? Please list:

_____

_____**U**

se of tobacco? (circle one) Never Daily Prior **Use of alcohol? (circle one)** Never Daily Occasional

Patient(print name):_____

Patient/Authorized Person Signature:_____

Relationship:_____ ***Date:***_____

Consent for Treatment

You expressly consent and agree that, in order to discuss or service your accounts(s) (the “Accounts “) or to collect amounts you may owe, Total Care Plus, and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively, “We”) 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 email address you provide 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.

_____ _____

Signature Date

Financial Responsibility

(Important Information Regarding Your Account)

Thank you for choosing Total Care Plus Urgent Care for your medical needs. In an effort to provide the most efficient experience possible, and avoid any misunderstanding, we have provided information regarding our financial policy. It is our policy that all charges are paid at the time of service. We accept, cash, Visa, Mastercard, Discover, American Express, Auto Ins, Worker's Compensation and Employer Paid Service accounts.

Self-Pay or Cash:

At Total Care Plus Urgent Care, we offer discounted prices (displayed in our lobby)to help those who do not have insurance. If you prefer to pay cash you may take advantage of these discounted prices, however please note that we will not provide any information to your insurance carrier regarding any charges made, or fees paid associated with a visit to which the cash discounted price was chosen. You will be required to pay for the office visit before services are rendered, and charges for additional services will be collected at time of visit.

Insurance:

If you have an insurance plan in which we participate, Total Care Plus Urgent Care will file a claim on your behalf. If you are unsure, please ask a Total Care Plus team member if your insurance plan is covered. Our filing a claim on your behalf does not guarantee that the insurance company will pay the claim, and does not relieve you of your responsibility for payments. Today you are required to pay your Urgent Care copay or coinsurance amount. If you have other insurance in which we do not participate with, you will be required to pay in full for todays services as self pay and we will provide you with necessary paperwork to submit to your insurance carrier for possible reimbursement.

Medicare:

If you have Medicare Part B we accept assignment on Medicare claims. This means we agree to accept Medicare's allowed amount as our full charge. Medicare pays only 80% of their allowed amount, and you are responsible for 20%coinsurance. Medicare does not pay for supplies and medications. You may be billed additional to cover these expenses. If you have a Medicare Supplement insurance policy, we will file a claim for you, and the 20% coinsurance will not be due at this time.

Travel Insurance:

If you are a visitor with a Travel Policy, we at Total Care Plus, require you to pay self pay for your services provided today. We will provide you with the necessary paperwork to submit to your insurance carrier for possible reimbursement.

Motor Vehicle Insurance:

If you have been in an MVA we require a claim number and all your policy information at the time of service. If your PIP insurance does not cover your entire visit, you will be responsible for the balance on your account.

Workers' Compensation Policy and Employer Paid Service Contracts:

If you are here for W/C injury or EPS, we will bill your employers w/c insurance carrier and accept this as payment in full providing the visit has been pre-approved by your employer an/or the insurance carrier by providing Total Care Plus with a claim number and w/c carrier information. If the insurance carrier or employer denies benefits, such as determining the injury was not work related, you will be personally responsible for the unpaid amount.

Other Policy Information:

If your insurance require prior authorization before seeking medical attention at Total Care Plus, you are responsible for getting that prior-authorization. Failure to do so may result in a denied claim. For delinquent accounts Total Care Plus, has the right to report non-payment to your health insurance provider;refer past due balances to an outside collection agency for collection and/or to report the past due balance to a credit reporting agency. You will be responsible for all past due balances in addition to the collection cost, including but not limited to collection agent or attorney fees. Should financial situations arise that prevent timely payment of your balance, you are encouraged to contact our Billing Department for assistance in the management of your account balance. There are instances in which we may develop a mutually acceptable payment plan until the balance is paid in full.

If your insurance information or address changes or you have questions please contact our office at 352-631-5560.

*Patient (print name):*_____

*Patient(or legal guardian's) Signature:*_____

*If legal guardian(relationship):*_____ *Date:*_____

CREDIT CARD/DEBIT CARD AUTHORIZATION

Total Care Plus LLC 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 an 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**. Total Care Plus LLC will not store any banking account data.

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

_____ _____

Cardholder's Authorization Signature **Date**

Please provide a valid email for notifications on charges that may occur from unpaid balances.

Email: _____