REASON FOR VISIT:

_____

URGENT CARE BY APPROXIE

NEW PATIENT REGISTRATION FORM

Patient Information

Name: _____ DOB: _____ Sex: _____

SSN#:_____

Address: _____ Apt: _____

Zip Code: _____ City / State: _____

Primary Phone #: _____ Alt Phone #: _____

Email Address (write clearly): _____

☐ Check to consent to receive medical records, billing statements and be contacted via email.

Primary Insurance Information

Insurance Brand: _____ Policy Holder: _____

Relation to Patient: _____ Sex: _____ Policy Holder DOB : _____

Policy or Contract #: _____ Group # (if plan has one): _____

Secondary Insurance Information

Insurance Brand: _____ Policy Holder: _____

Relation to Patient: _____ Sex: _____ Policy Holder DOB : _____

Policy or Contract #: _____ Group # (if plan has one): _____

Pharmacy Info (This is where we will send your prescriptions)

Pharmacy Name: _____ Preferred Location:_____

Quick Health History

Allergies	Reaction

Current Medications and Daily Supplements

Medication Name	Dosage	How Often	Reason for Medication

Signature:_____ **Date:** _____

******* **TURN PAGE OVER** *******

Consent to Medical Treatment: I voluntarily present for treatment and consent to treatment by an ApproXie health care provider. Such care may include, but is not limited to: diagnostic procedures, xrays, blood draws, laboratory tests, medication administration, and other procedures considered advisable in my diagnosis, treatment, and course of care. I acknowledge that my treatment is inteneded to address a specific episodic illness or injury and is not intended as a substitute for a primary care physician or other specialized physician, and that no guarantee can be made or has been made as to the results of treatments or examinations at ApproXie. **Initials:** _____

Notice of Privacy Practices: I acknowledge review of ApproXie Health's Notice of Privacy Practices, with a copy available upon request, as required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights. **Initials:**_____

Office Policy on Payment

It is ApproXie's policy to require all co-payments and or co-insurance payments to be made at the time of service. I understand that I give ApproXie Health and its affiliated billing parties permission to submit insurance claims on my behalf for services provided as a result of my care. I understand that any balance for my visit denied by insurance is my responsibility. I, the undersigned, accept the fee charged as legal and lawful debt and agree to pay said fee, including any / all collection agency fees, (33.33%), attorney fees and / or court costs, if such necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other state. I agree, in order for ApproXie to service my account or to collect monies I may owe, ApproXie Urgent Care and / or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. ApproXie and / or our agents may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded / artificial voice messages and / or use of an automatic dialing device, as applicable. I have read this diclosure and agree that ApproXie Urgent Care, its employees, and / or agents, may contact me by any permissible method described above.

Patients will be responsible for paying all costs associated with any testing or fees that are not covered by their insurance.

This includes but is not limited to deductibles, co-payments, co-insurance, and any other out-of-pocket expenses.

Signature: _____

Credit Card on File Policy

As a second attempt to collect (second to mailing statements), but prior to forwarding balances to a collection agency, balance payments will be made by charging a card that will be retained on file. Payment cards can include any credit, debit, or Health Savings card accepted at ApproXie Health. We do not accept Care Credit cards. **If my yearly deductible has not yet been met I understand that a $75 deposit per visit will be required until my deductible is met**. Any overpayment will be eligible for refund following successful payment by insurance for the claim.

Name on Card:_____ Card Number: _____

Expiration Date: _____ CVV: _____ Zip Code: _____

Type of Card (circle) Visa Mastercard Discover Amex

I give EMPOWER2 LLC d/b/a ApproXie Health permision to tokenize (keep on file) the credit card information listed above. The undersigned agrees to settle charges for any outstanding balance for services rendered with the card information on file.

Printed Name: _____ **Date Signed: _____**

Signature: _____