

PATIENT REGISTRATION



Patient Name: _____ Birthdate (MM/DD/YYYY): _____

Gender: M F Marital status: Married Single Divorced Widowed

Street Address: _____

(City/State/Zip): _____

Social Security #: _____ Email Address: _____

It is advised that you provide a private email address to which only you have access. For information about our Privacy Policy, please refer to: **Essential Med Clinic**

I consent to receive emails from Essential Med Clinic, other than those that come from the Patient Portal. I understand that these emails will be informational in nature, not contain any personal or confidential information and that I can click "Unsubscribe" at the bottom of any email to stop receiving them.

Tel. No.: Work: _____ Home: _____ Cell: _____

Caregiver: _____ Phone: _____

If student, school name: _____

What is the preferred language to receive information?

English Spanish Chinese Vietnamese Korean Other: _____

Race: Native Hawaiian or Other Pacific Islander African American Asian Hispanic White

European Other Race Refuse to report

How did you hear about this clinic?

Current Patient Family/Friend Clinic Event Health Plan and/or Representative Community Event

Advertisement Unavailable/Unknown Other: _____

PATIENT EMPLOYER INFORMATION

Employer Name: _____

Employer Address / Work No.: _____

Patient's Occupation: _____

INSURED PERSON (IF NOT PATIENT)

Name: _____ Birthdate (MM/DD/YYYY): _____
Tel.No.: Work: _____ Home: _____ Cell: _____
Street Address: _____ City/State/Zip: _____

EMERGENCY CONTACT

Name: _____ Birthdate (MM/DD/YYYY): _____
Tel.No.: Work: _____ Home: _____ Cell: _____
Street Address: _____ City/State/Zip: _____

INSURANCE

Do you have military benefits? Yes No

Primary Insurance Company: _____ Phone: _____

Address: _____

Group #: _____ Plan: _____ Certificate or ID# _____

Insured's Name: _____ Relationship to patient: self /spouse/ Dependent

Insured's Employer: _____ Phone #: _____

Employer Address: _____

Secondary Insurance Company: _____ ID#: _____ Plan: _____ Group: _____

Insured's Name: _____ Relationship to patient: self/spouse/Dependent

Insured's Employer: _____ Phone # _____

AUTHORIZATION TO RECEIVE EXTERNAL PRESCRIPTION HISTORY

I hereby authorize Essential Med Clinic and its affiliated providers to electronically retrieve my external prescription history. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions that date back several years.

I understand that Essential Med Clinic and its affiliated providers will use my external prescription history to: provide me with medical treatment, evaluate and improve the safety of their patients and improve the quality of medical care provided to me. I understand that I can revoke my permission at any time by giving written notice to my provider.

Signature of Patient or Legal Representative: _____ Date: _____

PHARMACY INFORMATION

Preferred Pharmacy: _____

Address: _____

Phone: _____

ASSIGNMENT OF BENEFITS

I hereby authorize Essential Med Clinic to apply for benefits, on my behalf, for covered services. I request that payment from my insurance company be made directly to Essential Med Clinic. I certify that the information I have reported with regard to my insurance coverage is correct.

I understand that I am responsible for payment of all medical services rendered. Any checks sent to me by my insurance company will be forwarded to this medical group to apply to my account, should a balance exist.

Signature of Patient or Legal Representative: _____ Date: _____

CONSENT TO TREAT

I, the undersigned, as/on the behalf of the patient, do hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the physician on duty.

Signature of Patient or Legal Representative: _____ Date: _____

FINANCIAL AGREEMENT- I agree that in return for the services provided by Essential Med Clinic, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Essential Med Clinic for payment. I hereby direct assignment of payment of medical benefits to Essential Med Clinic for services rendered. Accordingly, I accept full financial responsibility for all items or services, which are determined by my health care insurance plan not to be covered or applied to a co-pay, coinsurance or deductible. If you need to make special arrangements for payment, you may notify our staff to determine an alternate payment plan. Acceptance of any partial payment shall not extend any time period, cure any default, or be deemed to satisfy any remaining balance due. The balance of any account paid in full within ninety (90) days of the date of service will begin to accrue interest at the rate of 1.5% per month or the maximum allowed by applicable law, whichever is lower. If my account is deemed to be in default, I understand it will be sent to an agency for collections and I agree to pay an additional \$50.00 collection fee. A monthly statement will be mailed to the address listed for any outstanding balances.

INSURANCE PARTICIPATION: Essential Med Clinic will be happy to file a claim to your primary/secondary insurance carrier on your behalf. We will not, however, become involved in any disputes you may have with your insurance carrier. Our practice does not bill to any third party (e.g. school or auto insurance). You are responsible for knowing your insurance policy. You will be responsible for any charges if your health plan requires prior authorization before receiving services, and you have not obtained such authorization, your health plan determines that the services you received are not medically necessary and/ or not covered by your insurance plan; or your health plan coverage has lapsed or expired at the time you receive services; or you have chosen not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your insurance carrier.

PAYMENT FOR SERVICES: Essential Med Clinic accepts payment for services by cash, credit card or check and CareCredit. When you pay by credit card to be held on file to make monthly payments, you agree to keep the credit card information current and you authorize Essential Med Clinic to securely store your credit card information, and only charge it as agreed upon your payment plan. The storage system used is fully compliant to the highest level of credit card storage security regulations. Once stored, only the last four digits of your credit card are viewable by Essential Med Clinic personnel. Please be advised that payment by check binds you to contractual agreement that holds you responsible for any and all service fees, incidental damages allowable by law if the check is returned unpaid. Return check, state fees and incidental fees may be debited from your account electronically and by paper draft. Payment by check constitutes your acceptance of these terms. Essential Med Clinic does send all statements for balances via email and/or text messages.

Signature: _____

Date: _____

CONSENT FOR PHOTOGRAPHY, VIDEO/RECORDINGS

(Images taken for the purposes of treatment, payment and/or health care operations)

I consent to have my image taken by Essential Med Clinic for use of treatment, payment or healthcare operations. I understand that my image, including photographs, etc. will used be for the purpose of assisting my treatment or healthcare operations including quality initiatives. I understand that Essential Med Clinic will own these images. I may revoke or withdraw this consent at any time. Such withdrawal of consent must be made in writing. Withdrawal of consent does not affect any information prior to the written notice of withdrawal.

I certify this form has been fully explained to me and I understand its contents.

Signature of Patient or Legal Representative: _____

Date: _____