URGENT CARE

CATHOLIC MEDICAL CENTER

ClearChoiceMD

Date:_____ CCMD Staff Member:_____

Last Name:_____ First Name_____ M.I.:___

Date of Birth:_____ SS#:_____ Sex: Male / Female

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email:_____

Emergency Contact:_____ Phone:_____ Relationship:_____

Guarantor (person responsible for bill, if applicable):_____DOB:_____

Guarantor Address (if different from patient):_____ Relationship:_____

Insurance Policy Holder (if different from patient): _____

Insurance Policy Holder Date of Birth: _____

Primary Care Provider Name:_____

Pharmacy and Location:_____

Reason for Visit:_____

How did you hear about us?:_____ (Please be specific)

Please answer the following questions:

1. **Do you want your records sent to your primary care provider? Yes or No**
2. **I have read and understand the Consent for Treatment, Controlled Medication, Assignment of Benefits, Confidentiality, Complaint Procedure, Release of Information, Bill of Rights and Privacy Policies.**

   Yes or No

   Would you like a copy of these policies? Yes or No

3. **Follow-up communication: We may contact you after your visit in order to request feedback on your experience.**

   May we contact you via text message Yes or No

SEE OTHER SIDE

Co-Payments/Assignment of Benefits/Confidentiality/Release of Information/Privacy Practices/Consent for Treatment

Co-Payment

Please note that Co-Payments will be collected at the beginning of each visit and can be paid in any manner you choose. Please see your health insurance card or contact your insurer to understand the co-pay amount and any possible additional financial responsibilities as these may differ by plan.

Assignment of Benefits

I request that payment of authorized insurance benefits, including Medicare and/or Medicaid, be made on my behalf to the ClearChoiceMD, PLLC for any equipment or services provided to me by that organization

Statement of Confidentiality and Release of Information

I authorize the release of necessary medical information to ClearChoiceMD, PLLC for the purposes of processing these or any related insurance claims. I also give ClearChoiceMD, PLLC the authority to make available any requested documents contained in my file to myself and/or the other health care providers involved in the treatment of my condition.

Agreement and Notice of Privacy Practices

I understand that I am financially responsible for payment of this account regardless of insurance or third-party involvement. If the account is sent to an attorney or collection agency, I will be responsible for any agency or collection fee and/or court cost. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim.

By signing the consent form, I also acknowledge that I have been offered a copy of the organizations Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Consent for Treatment

I, hereby, authorize ClearChoiceMD Urgent Care, its medical providers, employees, or agents to provide medical evaluation and treatment as deemed necessary by the treating medical provider. This includes any medical examinations, x-rays/diagnostic procedures, or laboratory tests ordered by the treating medical provider to be carried out by designated staff.

Any comments, questions or inquiries should be directed to:

ClearChoiceMD, PLLC
74 Pleasant St, Suite 204
New London, NH 03257

Patient/Guardian Signature: _____ Date: _____

Patient/Guardian Printed Name:_____