CLEARCHOICEMD®
URGENT CARE

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 read the Notice of Privacy Practices that has been provided to you and the information on the reverse side of this form about Assignment of Benefits, Patients' Rights and Responsibilities, Complaint Procedure, Release of Information, and Consent for Treatment, then sign where indicated.

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

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-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 for any equipment or services provided to me by that organization.

Notice of Privacy Practices, Patient Rights and Responsibilities, and Complaints Procedure

By signing this form, I acknowledge that I have been given the organization's 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. By signing this form, I also acknowledge that I have been offered a copy of Patients' Rights and Responsibilities and the organization's Complaint Procedure, which are posted in the Center and on the organization's website.

Release of Information

I understand that ClearChoiceMD is authorized to release my personal health information to my health plan for the purposes of processing insurance claims for care I receive and to other health care providers involved in my medical care. I understand I may submit a written request for the restriction to ClearChoiceMD's disclosure of my PHI for these purposes and that ClearChoiceMD is not required to grant that request but will respond to my request in writing within 30 days of receipt of the request.

Financial Responsibility

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.

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 Urgent Care
10 Ferry St, Suite 302
Concord, NH 03301

Patient/Guardian Signature: _____ Date: _____

Patient/Guardian Printed Name: _____