



Patient Registration

Date: _____

Patient Name _____

Address _____

Street

City

State

ZIP

Home Phone _____ Cell Phone _____ Email _____

Sex _____ DOB _____ Age _____ SSN _____ Marital Status _____

Employer _____ Phone Number _____

Fill out this section, only if patient is under the age of 18, if not skip to next step.

Parent/Guardian: _____ Phone Number _____

Parent SSN _____ Parent DOB _____

Address _____

Street

City

State

ZIP

Employer _____ Occupation _____ Phone _____

Emergency Contact _____ Relationship _____ Phone _____

Primary Care Physician _____ Phone _____

Insurance Information

Primary Insurance _____ Policy # _____ Group # _____

Insured's Name _____ DOB _____ Relationship to Insured _____

Secondary Insurance _____ Policy # _____ Group # _____

Insured's Name _____ DOB _____ Relationship to Insured _____

Financial Policy

I authorize the release of any medical information necessary to process this claim. I permit a copy of the authorization to be used in place or the original. I hereby authorize St. Michael's Urgent Care to bill insurance on my behalf for the covered services rendered by the practitioner's and assign payment from my insurance company to St. Michael's Urgent Care or to the party who accepts payments. I certify that the information I have reported with regard to my insurance coverage is current and accurate.

I agree that I am financially responsible for all charges incurred whether or not they are covered by insurance. Self-pay patients must pay at time of service and any co-pays and deductibles must be paid at time of service. Upon response from my insurance company, I understand that all charges remaining are due and payable immediately. An interest fee of 2% per month (24% annually) may be charged to my account after 90 days. Accounts turned over to collections may be subject to a reasonable attorney/collection fee equal to (30%) of the outstanding balance. I understand that a \$40.00 (Forty dollar) NSF fee will be charged on all returned checks and they will be subject to be turned over to the District Attorney for collections.

I have read the St. Michaels' Urgent Care financial policy and understand that I, the patient or the patient's representative, am responsible for payment of all charges for services rendered..

Signature _____ Date _____