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 ______________________________