Washington Urgent Care

*2500 Mowry Ave., Suite 212, Fremont, CA 94538 *510-791-2273*

PLEASE PRINT ALL INFORMATION

Patient's Last Name: ________________________________ First:_________________________ Middle:__________

SS#:________-______-_________ Date of Birth: ______________________ Age:________ Male:____ or Female:____

Race: (please circle one)

White Asian African American East Indian Filipino Hispanic Native American Other: _______________

Single: ___Married: ___Widowed:____

E-Mail: ______________________________

Address: _________________________Apt#______ City: _______________State:_____ Zip: _____________

Home Phone#: (_____) ________________________Cell#: (_____) _______________________________

PLEASE LIST A RELATIVE OR FAMILY FRIEND

Emergency Contact:__________________________ Relationship to Patient: _______________

Emergency Phone Number: (______) _________________________

FINANCIAL RESPONSIBILITY Circle one: Self Parent/Guardian Other ________________________

(Insured Party) Relationship to Patient: _____________________________ **Date of Birth**: ___________________

Last Name: _______________________________ First: __________________________

INSURANCE INFORMATION

Primary Insurance: __________________________ PPO or POS or HMO= Medical Group _______________

ID# __________________________________ Group# _________________ Office Co-Pay $ __________________

Secondary Insurance ________________________ PPO POS HMO= Medical Group ________________________

ID# ____________ _____________ Group# ____________________ Subscriber's Name_____________________

(Insured Party) Relationship to patient: ______________________________ Date of Birth: ______________________

I consent to the treatment and/or procedure (s) necessary for the above named patient. If lab or X-ray is needed, Washington Urgent Care (WUC) may access my medical records through the Washington Hospital electronic system and I will receive a separate bill for laboratory services. I understand that payment of charges incurred is due at the time of service unless financial arrangements have been made prior to treatment. I further authorize and request that insurance payments be made directly to WUC.

Signature on this form acknowledges that I agree to bear full financial responsibility for all services provided that may not be covered by my insurance company for the following reasons: e.g., not a covered benefit, not referred or authorized, or determined not to be eligible for coverage with WUC and medical providers. I am aware that I have the right to appeal the insurance company's determination. If a denial is received, I will be responsible for the amount of this bill.

By signing this registration form, I consent to the use and disclosure of my (or the patient whom I'm authorized to consent for) protected health information for the purposes of treatment, payment, and health care operations, and acknowledge the posted current WUC Notice of Privacy Practices. Also by signing, I have read and fully understand the above consent of treatment and financial responsibility.

____ _________________________

Signature of Patient or Responsible Party **Date**

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