Registration Form

Ascent Urgent Care
& Walk-In Clinic

Today's Date: ________________________ Patient Gender _____Male _____Female

Form completed by: ______Self ______ Parent/Guardian _____Spouse _____Other

HOW DID YOU HEAR ABOUT US?	PHARMACY NAME: ______________________
Please circle one: ☐ Family ☐ Friend ☐ Mailer ☐ Internet ☐ Signage ☐ Work Others: _________	**CITY/LOCATION:** ______________________

Patient Information:

Patient Name ____
Last Name First Name Middle Initial

SS# (Age 18 and up) _________________________ Date of Birth _________________________

Permanent Mailing Address____
Number & Street City State Zip

Home Phone ___________________________ Cell Phone ___________________________

Marital Status: (Please circle one): ☐ Single ☐ Married ☐ Widow ☐ Divorced

Email:___________________________________ Emergency Contact Relation: ____________________

Emergency Contact: __________________________ Emergency Contact Phone: __________________

Physician Name _____________________________ Office Phone ___________________________

I authorize release of records to above physician if needed (please circle) **YES NO** ________**Initials**

Insurance Information – MUST BE FILLED OUT!

Primary Insurance __________________________ Secondary Insurance __________________________

Subscribers Name __________________________ Subscribers Name __________________________

Date of Birth __________________________ Date of Birth __________________________

Subscribers Employer __________________________ Subscribers Employer __________________________

Relationship to Patient __________________________ Relationship to patient __________________________

Subscriber Address (if different from above) ____

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Health History

PLEASE ANSWER ALL QUESTIONS, *PUT NONE IF NOT APPLICABLE*:

Reason for Today's Visit: ______________________________

Chronic Medical Problems	Previous Surgeries	Medication
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________t

DRUG ALLERGIES: ______________________ Quantity ____________

Smoker YES NO (ex: 1 pack/day) ____________ If former smoker, what year did you quit?

Family Health Problems (check if yes)

Diabetes ________ High BP ________

Stroke/Heart Attack ________ Cancer ________

High Cholesterol ________ Others? ________

Females Only:

Are you pregnant? YES NO N/A

When was your last menstrual cycle: ____________

Dear Patient,

The staff of Ascent Urgent Care & Walk-In Clinic provides professional health services. Due to many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. It is your responsibility to know your individual coverage. A charge of $35.00 will be applied to any account that is sent to collections. A $25.00 fee will be incurred for any returned checks. We require all insurance updates or changes to be made in writing within 30 days of your service date. Failure to do so will result in an inability to re-bill your insurance. Payment plans are available if set up within 30 days of your first statement. All assigned balances are due at the time of service prior to receiving care. Please remember your insurance policy is between you and your company and not with the Physician. For Work-related injuries, if your employer or the Workman's insurance does not pay, you the patient will be responsible for any charges incurred. By signing below, you hereby authorize your insurance benefits to be paid directly to Ascent Urgent Care & the on-staff physicians, realizing that you are responsible to pay non-covered services, and you hereby authorize the release of pertinent medical information to the insurance carriers.

Receipt of HIPAA (Health Insurance Portability and Accountability Act) Privacy Notice

Ascent Urgent Care is committed to maintaining the integrity of your protected health information and complies with all applicable state and federal regulations. In support of our policy of complying with all applicable regulations, Ascent Urgent Care provides patients with the HIPAA Notice of Privacy Rights. I acknowledge receipt of the Notice of Privacy Rights with detailed information about how Ascent Urgent Care may use and disclose my protected health information with my permission. I understand that Ascent Urgent Care reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me. While not required in order to receive treatment at Ascent Urgent Care, we are obliged under federal regulations to ask that you sign an acknowledgment of the HIPAA Privacy Notice being made available to you. (Refusal to sign does NOT prevent the patient from being treated)

Whom else do you give permission to send your medical records to: (ex: spouse, parents, friends, etc).

____

(Please write full name) ____________________ ____________

Signature of Patient or Parent/Guardian **Date:**

Front Desk Signature: ____________________ **Date:** ____________