

K+STAT URGENT CARE

REGISTRATION FORM

Name: _____
(Last, First, M.I.)
Address: _____ Apt # _____
City: _____ State _____ Zip _____
Employer: _____
Work Phone: _____
Emergency Contact: _____
Primary Care Physician: _____

Date of Birth: _____
Social Security #: _____
Sex: M F
Home Phone: _____
Cell Phone: _____
Emergency Contact Phone: _____

RESPONSIBLE PARTY INFORMATION

Name: _____
Address: _____
City: _____ State _____ Zip _____
Insurance Company: _____ Policy #: _____
(A photocopy of the medical insurance card will be taken)

Relation to Patient: _____
Social Security #: _____
Date of Birth: _____
Group #: _____

HIPPA CONSENT OF PRIVACY

I acknowledge that I have been given the opportunity to read and review the K+STAT Urgent Care's Notice of Privacy Practice. By signing this form I consent to the use and disclosure of protected health information for treatment and payment of healthcare operations.

*****Patient Signature/Parent or Legal Guardian: _____ Date: _____**

May we leave messages at home with other residents?	Yes*	No
May we contact you via cellular telephone?	Yes*	No
May we leave messages on your answering machine / voicemail?	Yes*	No

*We cannot assure the confidentiality of any information shared by these means.

Please list below all individuals with whom we may talk to about your medical concerns:

Name: _____ Relationship: _____
Name: _____ Relationship: _____

***** K+STAT OWNERSHIP *****

K+STAT Urgent Care is owned and operated by Stonecreek Family Physicians, LLP

INSURANCE AND ASSIGNMENT OF BENEFITS AUTHORIZATION INFORMATION

I hereby authorize treatment of the above named patient **AND** agree to pay all charges for treatment. I authorize the release of all medical information to the above insurance carrier that is pertinent to my medical care and necessary to process my insurance claim. I assign all benefits from contracting insurance companies to K+STAT Urgent Care. I understand that I can withdraw this medical benefit assignment at any time by notifying this office in writing. A photocopy of this form shall be as valid as the original. It is my understanding that K+STAT Urgent Care may send x-rays to an outside Radiologist for over-reading. I understand that I may incur additional charges as a result of that outside radiologist. For billing purposes, K+STAT Urgent Care has entered a business associate agreement with Stonecreek Family Physicians.

*****Patient Signature/Parent or Legal Guardian: _____ Date: _____**

