M.D. Express URGENT CARE

Place Patient Label Here

Office Use Only

Acct#:_____

Date: _____

Paid:$_____

CASH – CK – V – MC – DB – AX – D

Location (*circle one*)

GLOU HMPT NNWS WMBG YORK

Patient Registration Form

****Please Print****

Patient Information

First Name _____ MI _____ Last Name _____

SS# _____ Date of Birth _____ Age _____ Sex: M / F Marital Status: S M D W

Billing Address _____

City _____ State _____ Zip Code _____ Email _____

Home # _____ Mobile # _____ Work # _____

Primary Care Physician: _____ Employer: _____

- Is this a worker's compensation visit? Y N
- Is this visit for a motor vehicle accident? Y N

Responsible Party *(please complete if different from above)*

Name _____ Relationship _____

SS# _____ Date of Birth _____ Phone # _____

Billing Address _____

City _____ State _____ Zip Code _____

Insurance Statement

If no insurance information is obtained at the time of service, the patient will be considered a self-pay, and payment will be due at the time of service.

The patient is responsible for fees for all services rendered regardless of insurance coverage. All payments are due when the service is rendered. Due to carrier processing, we collect a PCP co-pay at the time of service when there is no urgent care co-pay stated. If your carrier leaves a higher cost share, you will be balance billed. The patient and/or the patient's insurance carrier may receive a separate bill for laboratory services and X-ray interpretations. These payments are due to the entity performing these services. M.D. Express has no control over the costs or terms of payment associated with these services.

M.D. Express charges a $50.00 fee for any returned check.

Patient Consent

I consent to the release of protected health information that is required to carry out treatment and payment for health care services performed on my behalf. I also consent to all treatments, as deemed appropriate by the treating physician, and agree to pay for all such services rendered and/or authorize my insurance company to pay M.D. Express directly. I accept responsibility for payment of all charges incurred, as well as all collection agency costs and or attorney fees, up to 33 1/3% should such collection action become necessary. I further attest that I have received, read and understand the Notice of Privacy Practices of M.D. Express. I understand that M.D. Express participates in the Virginia Prescription Monitoring program.

We would like to call you after your visit to see how you are doing. Please notify us if it is unacceptable to speak with a family member or leave a message on an answering machine.

Patient Signature: _____ Date: _____