Demographic Information

DATE ___________________________

LAST NAME ____ FIRST _____________________________ MI __________________

ADDRESS____ CITY ______________________ ST _____ ZIP _________________

EMAIL ADDRESS ____

HOME PH ________________________ CELL PH __________________________ EMPLOYER __________________________

DOB ____________________ Gender M F SS # _______- ______-_______ Marital Status S M W D Sep

EMERGENCY CONTACT____________________________ REL TO PT ________________________ PH ___________________

PRIMARY CARE PHYSICIAN _____________________________________ PHARMACY__________________________________

Primary Insurance

INSURANCE CO ____________________________________ POLICY HOLDER NAME___________________________________

DOB ________________________ GENDER M F SS #: _______-______- _______ PH____________________________

RELATIONSHIP TO PATIENT ________________________ ADDRESS IF DIFFERENT__________________________________

Secondary Insurance CITY, ST, ZIP____

INSURANCE CO _____________________________________ POLICY HOLDER NAME __________________________________

DOB ________________________ GENDER M F

Person Responsible For Bill (If Other Than Above)

LAST NAME ____ FIRST ____________________________ MI___________________

ADDRESS____ CITY _______________________ ST ____ ZIP __________________

HOME PH ______________________________________ CELL ____

DOB ____________________ SS # _____- _____-______ RELATIONSHIP TO PT ____

RACE (Please check)
___ Asian ___ Black or African American
___ Hispanic ___ White
___ Refused to Report/Unreported
Other __________________________

ETHNICITY (Please check)
___ Hispanic or Latino ___ Not Hispanic or Latino
___Refused to Report/Unreported Other ______________________

PREFERRED LANGUAGE (Please check)
____ English ____ Spanish Other _____________________

By my signature below I hereby acknowledge and authorize the following:

- Twin Rivers Urgent Care to treat the patient named above and agree to pay all fees and charges for services provided.
- Receipt of the HIPAA Consent regulations and requirements, the privacy practices and standard authorization regulations, and the disclosure of protected health information in use by Twin Rivers Urgent Care. (Additional copy available at the front counter.)
- Twin Rivers Urgent Care to release medical information necessary for the payment of claims and also to any physician for the continuum of my medical treatment.

SIGNATURE REQUIRED____ **DATE**__________________

Financial Policy

Patient: ____

1. I agree to provide Twin Rivers Urgent Care (TRUC) and/or its designated payment agent with my health saving/debit/credit card information.
2. I understand that my signature and payment information will be maintained through Navicure for future use by (TRUC). The applicable payment card or bank account number will be truncated and "tokenized" by the payment agent, Navicure, in order to maintain the security of my payment information.
3. I am responsible for all deductible, co-pay and co-insurance amounts and any/all services not covered by insurance.
4. Any payments or benefits due or paid by my insurance company are assigned to Twin Rivers Urgent Care.
5. I authorize TRUC and/or its designated payment agent to apply charges to my payment card and/or bank account for all amounts owed to the practice for medical visits, procedures or supplies, including (i) amounts agreed as part of a payment plan, (ii) copayments, (iii) coinsurance (after application of insurance proceeds), (iv) amounts not covered by insurance.
6. In the case of a patient balance that is not satisfied by a charge to my payment method I will receive a monthly statement for any outstanding balance via e-mail or U.S. mail.
7. Transaction receipts will be emailed to me if I provide and maintain a valid email address.
8. I understand that upon receipt of the insurance payment the credit card on file will be billed for the entire balance.
9. I understand this agreement remains valid until I cancel the authorization through written notice to Twin Rivers Urgent Care, LLC, at which time I will pay any outstanding patient balance in full. I understand that I can cancel the authorization only for future services. Authorization for services already rendered cannot be cancelled or refunded.
10. Returned check fees of $20 may be charged for any insufficient funds checks and a 15% annual fee will be applied to each claim referred to a collection agency.
11. Non-insured patients are required to pay all charges in full on the day of service unless other arrangements have been made. Payment on day of service makes patient eligible for a quick pay adjustment.

Please charge the payment method on file according to the following EZ Pay payment plan:

ALL BALANCES IN FULL

I will leave a $100.00 deposit at my visit today.

Charges for the following family members:

____

Card Holder Information: ******ALL FIELDS BELOW ARE REQUIRED******

EMAIL ADDRESS ____

ZIP CODE ______________________________ **DATE** ______________________________

SIGNATURE ____

Patient ID (Internal use only): ____

1/29/2016