AMD URGENT CARE SC

7070 Miller Rd Suite A
Swartz Creek, MI 48473
Office: (810) 564-7995 opt: 3
Fax: (810) 221-1340
Email: amdurgentcare@gmail.c

Number:

Hippa and Hitech release
Please take a moment to thoroughly read and fill out *ALL* of the highlighted information.

What is the reason for your visit?_____Todays Date:_____

Print Name: (First, Middle, Last)			Date of Birth:		
Social Security Number:			Email:		
Cell Phone:	Home Phone:		Sex: **M F**	Race:	Ethnicity: **Hispanic Non Hispanic**
Patient Address:	City/State		Zip Code:	Marital Status: **S M D W**	
Patients Emergency Contact	Emergency Phone:		Relationship to the Patient:		
IF UNDER 18 YEARS: Parent/Guardian Name:	Parent/Guardian Home/Cell #		Parent/Guardian Relation:		
Parent/Guardian Social Security Number:					

Primary Care Physicians Name X_____

Do you want all MEDICAL RECORDS released to Primary Care Physicain YES_____ NO _____

How did you hear about us? (please circle one) Referral Radio Internet Mail Placemat TV

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INSURANCE INFORMATION

PRIMARY Insurance Company:	ID or Policy #:	Group #:	
Policy Holders Name:	Policy Holders Social Security Number:	Policy Holder Date of Birth:	
Patient Relationship to Policy Holder:	Policy Holders Sex: **M F**	Policy Holders Phone Number:	Co-Pay:
SECONDARY Insurance Company:	ID or Policy #:	Group #:	
Policy Holders Name:	Policy Holders Social Security Number:	Policy Holder Date of Birth:	
Patient Relationship to Policy Holder:	Policy Holders Sex: **M F**	Policy Holders Phone Number:	Co-Pay:

EMPLOYER INFORMATION

Insurance Policy Holders Employer:	Address:
Phone Number"	Contact:

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Financial Policy

We would like to thank you for choosing us to provide your care. As one of our patients, we would like to keep you informed of our current office and financial policies. We require a signature to document that you have read, understand and agree to these policies.

Payment is required at the time of service. This includes but is not limited to copayments, deductibles or coinsurance for participating insurance companies. We accept cash, personal check, VISA and MasterCard. There is a service charge of $35.00 for returned checks.

The person signing this Financial Policy agrees to pay all charges incurred. The person also agrees to pay all copays and deductible required by insurance contracts, and any charges or portion thereof for which payment is denied by insurance for whatever reason, or if there is no insurance coverage.

As a courtesy to you, we will bill your insurance company directly. The issue of partial or non-payment of your medical bills is a matter between you and your insurance company. All professional services provided will be charged to the patient and the patient will be responsible. ***Co-payments and deductibles are due at the time of service. Patients not utilizing insurance plans are expected to pay at the time of service.***

Insurance/Photo Identification Cards

It is the patient's responsibility to provide us with current insurance information and to present an **ACTIVE INSURANCE CARDS AT EACH VISIT**. If your insurance plan requires, you must obtain advance approval to be seen by our doctors**. PHOTO IDENTIFICATION MUST BE PRESENT** for patients 18yrs or older, under 18yrs must be accompanied by a legal guardian with proper identification.

Past Due Accounts

Please call if you have any questions about your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings of your bill being sent to collections. If you are having any trouble paying your bill, please discuss the situation with us. Satisfactory arrangements can almost always be made.

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Assignment of Benefits AND Authorization to Bill Insurance

I hereby authorize AMD Urgent Medical Care and/or any provder of AMD Urgent Medical Care to apply benefits on my behalf for services rendered. I request and authorize payment from my insurer to be made directly to AMD Urgent Medical Care/or such provider. The insurance information I have reported to you is correct and I authorize the release of any necessary information, including medical information for this or any related claim, to my insurance company. A copy or image of this authorization may be used in place of the original. Payment for all professional services is the responsibility of the patient, parent or guardian. AMD Urgent Medical Care assists in the preparation of the insurance forms to help expedite the payment. The patient is however responsible for payment for all professional services regardless of the insurance coverage.

X_____ Date _____

Patient, Parent, or Legal Guardian Signature

Financial Policy

I have fully and carefully; read, understand, and agree to all the terms of this Financial Policy.

X_____Date_____

Patient, Parent, or Legal Guardian Signature

HIPAA/Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of AMD Urgent Medical Care's Notice of Privacy Practices. AMD's goal is to follow HIPPA law as close as possible. AMD has implemented the HITECT ACT and Omibus rule Change. (January 2014)

X _____Date _____

Patient, Parent, or Legal Guardian Signature

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Cash Pay Patients

As a courtesy to you, we will offer a discount on the following services based on the fee being paid in full at the time of service. All patients who pay the balance will receive the following care for a flat fee of _____. If AMD is aware of any health insurance we are obligated to bill said insurance at our contracted rates. All deductibles and copays will be the patients responsibilitiy as dicatated by their insurance carrier.

ONLY the following will be eligible for the non-insured office visit discount:

1. Visit with the provider
2. In office X-rays
3. Medications and injections (excluding IV's)
4. Urinalysis test
5. Pregnancy test
6. Breathing Treatments

There may be circumstances that require additional medical treatment, such as: in office procedures, lacerations, fractures, etc… These treatments will require additional medical treatment and related costs, this cost will be based on the Blue Cross Blue Shield fee schedule and should be paid at the time of service or upon receipt of statement.

By signing this document, you (patient) agree to pay for any additional costs included in your visit. The staff at AMD will do their best to inform patients prior to treatment, however, in the event the staff does not inform the patient prior to services, by signing this document the patient takes full responsibility for any costs above and beyond the self pay office visit fee. In the event the patient does not pay the office visit fee in full at time of service any discounts applied will be removed and billed according to the Blue Cross Blue Shield fee schedule.

Patient/Guardian Signature _____Date:_____