CARE PLUS
Primary Care • Urgent Care

❑ 8914 US Highway 431 • Albertville, AL 35950
❑ 700 Quintard Avenue • Anniston, AL 36201
❑ 11100 S. Memorial Pkwy • Huntsville, AL 35803

PATIENT REGISTRATION

❑ NEW PATIENT ❑ EXISTING PATIENT

PATIENT INFORMATION

TODAY'S DATE: ____/____/____ GENDER ☐ MALE ☐ FEMALE

NAME: _____ SOCIAL SEC. NUM. ____ - ____ - ____
Last First Middle

HOME PHONE ☐ PREFERRED _____ CELL PHONE ☐ PREFERRED _____

WORK PHONE ☐ PREFERRED _____ EMAIL _____

MAILING ADDRESS _____ APT. # _____

CITY _____ STATE _____ ZIP _____

AGE ____ BIRTHDATE ____/____/____ MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Cohabitate

RACE ☐ Asian ☐ American Indian / Alaska Native ☐ White ☐ Native Hawaiian / Other Pacific Islander ☐ Other ☐ Black / African American ☐ Decline

ETHNICITY ☐ Hispanic / Latino ☐ Not Hispanic / Latino ☐ Decline

PRIMARY LANGUAGE ☐ English ☐ Other

DRIVERS LICENSE # _____ STATE ____ EMPLOYER _____

PHARMACY NAME _____ PHARMACY PHONE NUMBER _____

PHARMACY LOCATION (SHOPPING CENTER / STREET, CITY, STATE) _____

HOW DID YOU HEAR ABOUT US?

☐ Relative/Friend Name _____ ☐ Health Insurance Website ☐ Facebook / Twitter ☐ Angie's List
☐ Internet Search (which website) _____ ☐ Health Fair (which one) _____ ☐ Other _____

INSURANCE INFORMATION:

Please present all insurance cards to the Receptionist to be copied. If you do not have your card or your insurance can not be verified on the date of your visit, you may be required to pay for services rendered. Please provide copy of card(s).

PRIMARY INSURANCE: _____ Subscriber's DOB ____/____/____

Subscriber Name _____ Contract # _____ Group # _____

Subscriber Social Security Number ____ - ____ - ____ Relationship to Patient _____

Subscriber Employer _____ Effective Date ____/____/____

SECONDARY INSURANCE: _____ Subscriber's DOB ____/____/____

Subscriber Name _____ Contract # _____ Group # _____

Subscriber Social Security Number ____ - ____ - ____ Relationship to Patient _____

Subscriber Employer _____ Effective Date ____/____/____

IF PATIENT IS A MINOR, PLEASE PROVIDE PARENT AND OR LEGAL GUARDIAN'S INFORMATION

Full Name _____ DOB ____/____/____ RelationshipTo Patient _____

Address _____ City _____ State _____ Zip _____ Phone # _____

Full Name _____ DOB ____/____/____ RelationshipTo Patient _____

Address _____ City _____ State _____ Zip _____ Phone # _____

EMERGENCY CONTACT:

Name _____ Relationship _____ Phone # _____

I, the undersigned, have read the above comments, statements and releases and I have executed this instrument voluntarily.

Signature of Responsible Party _____ Relationship to Patient _____ Date ____/____/____

Signature of Care Plus Witness _____ Date ____/____/____

CONDITIONS OF REGISTRATION

THE PRACTICE

CAREPLUS and/or its physicians, employees, agents or assignees will hereafter be referred to as "*The Practice*"

CONSENT FOR TREATMENT

The undersigned consents to the administration of medical treatment, diagnostic and/or therapeutic procedures and minor surgical intervention as required by the healthcare provider rendering care for themselves and/or their child(ren). The procedures may include, but are not limited to, lab, x-ray, or minor surgical procedure.

HIV/HEPATITIS B & C TESTING NOTIFICATION

In accordance with Alabama State Law, any patient whose blood and/or body fluids a healthcare worker has been exposed, will be deemed to consent for HIV/HEPATITIS B & C TESTING. In all other cases, the patient shall have the right to be informed consent or refusal for HIV/HEPATITIS B & C TESTING.

AUTHORIZATION & ASSIGNMENT OF INSURANCE BENEFITS

The undersigned authorizes *The Practice* to apply for benefits for services rendered to myself or minor child(ren) under the terms of any health insurance policies/programs providing benefits and do hereby also assign and authorize payment of benefits from insurance company to *The Practice*. I authorize *The Practice* to contact the employer or insurance company regarding insurance information, existence of insurance and coverage of benefits. I understand that I am responsible for the medical charges not covered by (prior) authorization.

RELEASE OF MEDICAL INFORAMTION

I authorize *The Practice* to release any and all of my or my minor child(ren)'s medical records and/or other information and records required by my (our) insurance company or its designated review agents who provide insurance benefits on my (our) behalf, including if applicable, my employer and/or employer's workman's compensation insurance company or the Centers for Medicare & Medicaid Services, needed to determine benefits and to process insurance claims and secure payment of benefits to either the insured or to *The Practice*; and authorize any other hospital, lab, physician, or other healthcare provider and/or their staff to release my or my minor child(ren)'s medical records and/or other records and information on myself or my minor child(ren) to *The Practice* as required for payment of benefits and/or required for medical and other reasons; and authorize *The Practice* to release the above mentioned records for any of the above reasons. I agree to pay any applicable charges for having medical records copied.

REFERRALS AND AUTHORIZATIONS

I understand that it is my responsibility, if I have an insurance plan that requires any referrals, pre-certifications or authorizations to receive any additional medical services, such as specialty care and diagnostic testing, to obtain such authorization from *The Practice* or insurance company prior to such non-emergency services being rendered. I further understand that I must notify *The Practice* prior to going, if possible, or within 48 hours, or in accordance with my insurance company's requirements, of any emergency room visit. Additionally, if any aforementioned procedures are not done, I understand that this may cause reduced or rejected coverage for which I will be held responsible and that any of these aforementioned actions do not guarantee that my insurance company will pay for my or my child(ren)s claims. Any denial of claims is between the policyholder/subscriber and their insurance company. I agree to inform *The Practice* immediately of any change in insurance coverage and/or benefits and change of personal information.

FINANCIAL AGREEMENT

The Practice will file for insurance benefits and accept payment per the *The Practice's* contractual agreements with participating insurance companies. Any questions or disputes concerning insurance coverage or payment of benefits is a matter between the insurance subscriber/policyholder and the insurance company. Any assistance in this matter granted by *The Practice* is given strictly as a courtesy and implies no responsibility on *The Practice's* part for filing, follow through or confirmation.

As consideration for *The Practice* rendering service to the patient, the patient or responsible party agrees to pay all charges for service rendered at the time of such services, unless prior arrangement has been made with Managerial Staff only. Patient co-pay/deductible must be satisfied prior to medical care visit and all balances are due at time of check out. Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, failure to add a dependent to insurance plan, non-payment at time of service, or any other reason, I agree to pay all balances within **30 days** of services rendered. If payment is not received within **30 days**, *The Practice*, will make a reasonable effort to collect then, at its discretion may place the unpaid balance with a collection agency and/or Attorney. The patient or responsible party for the account agrees to pay a reasonable collection fee, attorney fee, court cost and any other cost of collection proceedings.

I understand that I may be billed separately for services rendered by other professionals, including but not limited to reference lab (LabCorp/Quest), radiologist, or any other entity identified at time of testing.

I agree to payment of the following fees, when applicable. Simple Form completion $15; Complex Form completion $60; Non-controlled Prescription refill without office visit $20; Missed Special Procedure scheduled appointment $35; Returned Check fee $30 (or allowable by District Attorney); 5% late fee on account balance payment plan, assessed every 28 days; any additional fees posted. I understand these fees will be my financial responsibility and NOT sent to insurance company.

If my insurance requires selection of a PCP (Primary Care Physician) and I have not selected *The Practice* or one of its providers, or have not obtained the proper referral from my assigned PCP, I agree that I am financially responsible for 100% of incurred charges.

COPY OF SIGNATURE

I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of any medical records and/or other records and information, as stated herein, whether manual, electronic, or telephonic for the purpose of payment, treatment or operations.

CERTIFICATION

I certify that the information I have reported with regard to my insurance coverage is correct and that the above be honored by my insurance carriers.

I certify that the information I have reported above is correct and that as the Patient/Parent/Guardian/Guarantor I have read, understand and fully accept the Condition of Registration as stated on this document.

SIGNATURE OF PATIENT, PARENT, GUARDIAN, GUARANTOR	PRINTED NAME	RELATIONSHIP	DATE