Manatee Urgent Care

PRACTICE NOTICES

FINANCIAL AGREEMENT: The undersigned hereby authorizes the release of any and all information or documents to all parties related to obtaining my insurance benefits for claims submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician and all necessary parties to submit claims to obtain benefits for services rendered without obtaining my signature on each claim submitted for myself and/or dependents. I hereby authorize my insurance company to pay and hereby assign benefits directly to Manatee Physician Alliance, LLC. I further acknowledge that any insurance benefits, when received and paid, will be credited to my account, in accordance with my insurance company's assignment. Any unpaid charges are my responsibility in accordance with any contractual agreements with my insurance and when governed by state/federal law. Full payment is due at the time of delivery of service unless other arrangements have been made or mandated by law. I understand that I have the primary duty and obligation to pay my doctor for his/her services, notwithstanding any contract I may have with any third party payer (i.e. insurance company, employer, etc.). I understand that as a recipient of medical care I, the undersigned, am responsible for all charges regardless of my circumstances for reimbursement.

HIPAA DISCLOSURE: By signing below, I understand that Manatee Physician Alliance shall not publish or otherwise make generally available any protected individually identifiable health information or data that identifies a patient for purposes other than treatment, payment or other health care operations without his/her express written consent. I understand that this does not restrict the internal use of such information or data that is required in the performance of the scope of work that this office has been engaged to perform for patients. I understand that this office maintains physical, electronic, and procedural safeguards to protect individually identifiable health information. As a patient of Manatee Physician Alliance, I understand that I have the right to request special privacy protections. I have the right to request restrictions on certain uses and disclosure of my health information, by written request specifying what information I want to limit and what limitations on use or disclosure of that information I wish to have imposed. I hereby acknowledge that this medical practices' Notice of Privacy Practices has been made available to me. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of this notice.

Signature of Patient or Responsible Party	If person signing is not patient, please state relationship	Date

Manatee
Urgent Care

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1. _____ I authorize the release of any and all information or documents to all parties related to obtaining my insurance benefits for claims submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician and all necessary parties to submit claims to obtain benefits for services rendered without obtaining my signature on each claim submitted for myself and/or dependents. I hereby authorize my insurance company to pay and hereby assign benefits directly to Manatee Physician Alliance, LLC. I further acknowledge that any insurance benefits, when received and paid, will be credited to my account, in accordance with my insurance company's assignment.

2. _____ **I understand that the facility rendering services is set up as a Walk-In Clinic and services will be billed to my insurance as a standard office visit. Charges will not be applied toward Urgent Care Benefits.**

3. _____ I understand that my **HMO insurance plan** may require a referral from my primary physician. I authorize Bradenton Urgent Care Clinics to request a referral from my primary care provider, as a courtesy to me. I understand that I am responsible for verifying a referral is issued within the designated time frame set forth by my insurance plan.

4. _____ I understand that Bradenton Urgent Care Clinics may be **out of network** with my insurance plan. I agree to the option selected below: (choose one)

_____ I authorize a claim for services provided to be submitted to my insurance carrier. I understand that I am financially responsible for any and all out-of-network fees.

_____ I would like to take advantage of Bradenton Urgent Care Clinics' self-pay rates. I understand that full payment for services rendered is due at time of service. I acknowledge and agree that by failing to pay in full at time of service, I will be financially responsible for out-of-network fees determined by my insurance carrier.

5. _____ I acknowledge that my insurance plan states I have an **annual deductible**. I agree to pay $100.00 towards my deductible at time of services rendered. I understand that I am financially responsible for any fees not paid by my insurance plan.

By signing this agreement, I acknowledge and agree that any unpaid charges are my responsibility in accordance with any contractual agreements with my insurance and when governed by state/federal law. I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance, deductible or charges not covered by insurance.

_____ _____ _____

Patient/Guardian Name Patient/Guardian Signature Date

PATIENT DEMOGRAPHICS

Patient Information

Last Name	First Name	Middle Name	Suffix	Social Security #

Gender (circle)	Date of Birth	Marital Status (circle)	Primary Care Physician
M / F		*Divorced - Married - Separated - Single - Widowed - Other*	

Preferred Language (circle)	Race (circle)	Ethnicity (circle)
English - Spanish - _____	*Asian - Black - White - Other: _____*	*Hispanic - Not Hispanic - Unknown*

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Email Address	How did you hear about us?	Referring Physician

Responsible Party

Check if same as: [ ] Patient

Last Name	First Name	Gender (circle)	Date of Birth	What is Patient's Relationship to Responsible Party?
		M / F		

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Employer Information

Employer	Address	City / State	Zipcode

Emergency Contact

Check if same as: [ ] Responsible Party

Last Name	First Name	Gender (circle)	Date of Birth	What is Patient's Relationship to Emergency Contact?
		M / F		

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Guardian Contact

Check if same as: [ ] Responsible Party [ ] Emergency Contact

Last Name	First Name	Gender (circle)	Date of Birth	What is Patient's Relationship to Guardian?
		M / F		

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Insurance Information

Check if: [ ] Self Pay

Check if same as: [ ] Responsible Party			Check if same as: [ ] Responsible Party		
Subscriber / Member Name		Date of Birth	Subscriber / Member Name		Date of Birth
What is Patient's Relationship to Subscriber?		Gender (circle) *M / F*	What is Patient's Relationship to Subscriber?		Gender (circle) *M / F*
Primary Insurance Company		Begin Date	Secondary Insurance Company		Begin Date
Insurance Mailing Address	City / State	Zipcode	Insurance Mailing Address	City / State	Zipcode
Subscriber / Member #	Group #		Subscriber / Member #	Group #	

Patient/Legal Guardian Signature Date

Patient/Legal Guardian Print

Manatee
Urgent Care

Patient Name:_____ __ _____Date of Birth:_____

If you are having chest pain or shortness of breath, please let the front desk know immediately!

What is the reason for your visit today? _____

_____

Which pharmacy would you like your prescriptions to go to?

Pharmacy Name: _____

Pharmacy Location: _____

Is today's visit related to a Motor Vehicle Accident or a Work Related Injury? Yes or No

Are you **ALLERGIC** to any Medications?

Name: _____ Reaction: _____

Name: _____ Reaction: _____

List of Medications **CURRENTLY** taking; prescribed or over the counter:

Name: _____ Strength: _____ How Often: _____
Name: _____ Strength: _____ How Often: _____
Name: _____ Strength: _____ How Often: _____
Name: _____ Strength: _____ How Often: _____
Name: _____ Strength: _____ How Often: _____
Name: _____ Strength: _____ How Often: _____

If you have additional medications please list on the back of the form.

Patient Signature _____ Date: _____

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Physician Alliance

Manatee Urgent Care

Patient Name: _____Date of Birth:_____

If you are having chest pain or shortness of breath, please let the front desk know immediately!

What is the reason for your visit today? _____

_____

Is your complaint today in regards to a Motor Vehicle Accident or Workman's Comp? Yes No

Which pharmacy would you like your prescriptions to go to? _____

Location: _____

Has there been a change in your address from your last visit? Yes No
If yes, please indicate: _____

Has there been a change in your phone number from your last visit? Yes No
If yes, please indicate: _____

Are you allergic to any medications?	Has there been a change in your prescription medication since your last visit?
YES NO	YES NO
If yes please indicate: _____	If yes indicate: _____

E-Mail Address: _____

Are you interested in receiving information about the patient portal? Yes OR No

Patient Signature _____ Date: _____

Manatee Physician Alliance

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_____	_____	_____
Patient/Guardian Name	Patient/Guardian Signature	Date

Manatee
Urgent Care

Medical Information Release and Message Authorization

I give permission to Manatee Physician Alliance to release my medical information to the following people named below (this does not apply to other physicians: it does apply to family members, friends and others with whom you would allow such information to be shared).

Please **PRINT**

Name and relationship: _____

Name and relationship: _____

Name and relationship: _____

Name and relationship: _____

I authorize the providers and representatives of Manatee Physician Alliance to leave messages regarding my test results/appointments/financial information on my voicemail at numbers below if they do not reach me.

Please CIRCLE **all** that apply: HOME CELL WORK

I authorize the providers and representatives of Manatee Physician Alliance to leave messages regarding my test results/appointments/financial information with any of the above authorized people, if they do not reach me.

Please CIRCLE: YES NO

Signed:_____ Date of Birth:_____

Print Name:_____ Date Signed:_____

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