Arlington URGENT CARE
3062 Kingsdale Center
Upper Arlington, Ohio 43221

Bexley URGENT CARE
2216 E. Main St.
Bexley, Ohio 43209

Worthington URGENT CARE
2245 W. Dublin-Granville Rd., #101
Columbus, Ohio 43085

PATIENT REGISTRATION

Please complete all sections of this form**.**

Please alert a staff member IMMEDIATELY if you are experiencing any of the following: CHEST PAIN, SHORTNESS OF BREATH, FACIAL DROOPING, SLURRED SPEECH AND/OR A TEMPERATURE ABOVE 101 DEGREES F, or if you are pregnant or think you may be pregnant.

A: Demographics

Last Name: _____ First Name: _____ MI: _____

SSN:_____*_*required_* Birthdate:_____ Gender: Male / Female OR Specify: _____

Address:_____City:_____ST:_____Zip Code: _____

Cell Phone:_____☐ OK to leave message Home Phone:_____☐OK to leave message

Email:_____Marital Status: _____

Race:_____ Ethnicity: Hispanic or Non-Hispanic Preferred Language: _____

Emergency Contact:_____Phone:_____Relationship:_____

Reason for today's visit: _____

Medications:_____OR ☐See attached list

☐ Medication Allergies:_____

☐ Other Allergies:_____

Preferred Pharmacy_____Address:_____Zip_____

Primary Care Physician:_____Phone:_____Fax:_____

How did you hear about us?_____

Employer:_____Title:_____Employer Phone: _____

Parent/Guardian if patient is under 18 years old.

Name:_____ Relationship: _____

SSN of Guardian:_____*_*required_* Birthdate_____*_*required_* Phone: _____

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B: Insurance

*We do not accept any Ohio Medicaid plans, including CareSource, Molina, Buckeye Health Plan, Paramount Advantage and United Healthcare Community Plan of Ohio.

☐ I do not have private health insurance: If you do not have private health insurance skip to section C.

☐ **THIS IS A WORK-RELATED INJURY**. (Please alert the receptionist. You **must** provide health insurance for work related injuries and complete the appropriate paperwork for the Bureau of Worker's Compensation)

☐ This is the result of a motor vehicle accident. You will be required to review and sign our self-pay policy. You will be provided a receipt.

Primary Insurance:_____Co-Pay:_____

Member ID:_____ Group Number:_____

Policy Holder's Name:_____Relationship to patient: _____

Birthdate:_____*_required_ Gender: Male or Female SSN:_____*required*

Insured Address:_____City:_____ST:_____Zip Code: _____

Phone: _____

Secondary Insurance: (if applicable):_____Co-Pay: _____

Member ID:_____ Group Number:_____

Policy Holder's Name:_____Relationship to patient: _____

Birthdate:_____*_required_ Gender: Male or Female SSN:_____*required*

Insured Address:_____City:_____ST:_____Zip Code: _____

Phone: _____

C: Acknowledgement of Arlington Urgent Care Notice of Privacy Practices

- I hereby acknowledge that I have reviewed, received, or have been given the opportunity to receive a copy of Arlington Urgent Care, Inc.'s Notice of Privacy Practices (attached to clipboard).
- I have read, understand, and agree to the attached Financial Policy. I am aware that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.
- I authorize my insurance benefits be paid directly to Arlington Urgent Care, Inc.
- I authorize Arlington Urgent Care, Inc. through its appropriate personnel, to perform upon me, or the above-named patient, appropriate assessment and treatment procedures.
- I authorize Arlington Urgent Care, Inc to release to appropriate agencies, any information acquired during my or the above-named patient's examination and treatment.
- I agree to have my insurance, or self, charged for all services utilized by an outside facility including, but not limited to, laboratory analysis. • I expressly consent and agree that, in order to discuss or service your accounts(s) (the "Accounts ") or to collect amounts I may owe, Arlington Urgent Care, Inc. and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively, "We") may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contact you by sending text messages, emails, using any e- mail address you provide to us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

Patient *or* Guardian Signature:_____**Date**: _____