Arlington URGENT CARE | Bexley URGENT CARE | Worthington URGENT CARE

Established Patient Check-In Form

Welcome back! Please use this form to update any patient data for our records.

If nothing has changed, please indicate below then review the attached financial policy and sign at the bottom.

If your insurance information has changed, please provide a copy of the card to the receptionist.

First Name:__________________Last Name:________________________MI: DOB: ___________________

Reason for Today's Visit: ____

Current Medications: ____

☐Drug Allergies ____

Preferred Pharmacy:____________________________________**Pharmacy Zip Code**: ____________________

Email:____

Please update all insurance and demographic information. (if there has been a change)

☐No change to demographics or insurance.

Address:__________________________City:________________ST:________Zip Code: ________________

Home Phone:_______________☐OK to leave a message Cell Phone:________________☐OK to leave a message

Marital Status: ________________________Primary Care Physician: _____________________________________

Emergency Contact:_________________Phone:___________________Relationship____________________

☐I do not have health insurance

Primary Insurance:____Co-Pay: ___________________________

Insured Name:_________________________Relationship:________________Birthdate:_____________*required*

SSN:__________________________*required* Gender: Male or Female Phone:______________________________

Address:________________________________City:__________________ST:________Zip Code: ____________

Secondary Insurance (if applicable)___________________________________Co-Pay:__________________________

Insured Name:___________________________Relationship:________________Birthdate:_____________________

SSN:______________________________Gender: Male or Female Phone: ____________________________________

☐THIS IS A WORK RELATED INJURY. (Please alert the receptionist. You must still provide health insurance for work related injuries)

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's Notice of Privacy Practices.
- 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. If I do not have health insurance, I will be responsible for all charges from today's visit and agree to pay in a timely manner.
- I authorize my insurance benefits be paid directly to Arlington Urgent Care.
- I authorize Arlington Urgent Care, through its appropriate personnel, to perform upon me, or the above named patient, appropriate assessment and treatment procedures.
- I authorize Arlington Urgent Care to release to appropriate agencies, any information acquired in the course of 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.

Patient/Guardian Signature:____Date: _________________

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

CREDIT CARD AUTHORIZATION

Date of Service (Today's Date): _________________

Arlington Urgent Care, Inc. submits claims to insurance carriers as a convenience to all our patients. At this time, we request authorization to balance bill a major credit/debit card to cover amounts determined by your insurance to be your responsibility. These amounts may be due to unpaid portions of deductibles, co-pays, co-insurances or in the event of a non-covered service.

Upon receipt of an explanation of benefits (EOB) from your insurance carrier any unpaid portion of your claim will be billed to your credit/debit card. Should insurance pay in full, your account will not be charged.

This authorization is valid only for ninety days from the Date of Service listed above and will not qualify for any past or future visits.

All credit/debit card information will remain absolutely confidential and securely stored by **First Data,** one of the world's largest merchant services provider. Arlington Urgent Care, Inc. will not store any banking account data.

Please complete the information below:

I _________________________ authorize Arlington Urgent Care, Inc. to charge my credit card account for the total fees owed by me, such as fees applied to copays, deductibles, or co-insurances, not to exceed $150.00.
I hereby authorize Arlington Urgent Care, Inc. to charge any and all outstanding balances for the date of service listed above, after insurance company reimbursement or denial, up to $150.00 to my credit card. I understand that I will not receive a statement if there is no balance due after processing my credit card for payment.

____ ______________________
Cardholder's Authorization Signature **Date**

____
Email