Piedmont UrgentCare BY WellStreet

ONLINE REGISTRATION FORM

PLEASE FILL IN ALL INFORMATION ON THIS FORM WHERE APPLICABLE

PATIENT INFORMATION					
Last Name:		**First Name:**			
Middle Name:		**Nickname:**			
SSN:		**Gender:**	☐ Male ☐ Female		
Date of Birth:		**Marital Status:**			
Address:					
City:		**State:**		**Zip:**	
Cell Phone:		**Home Phone:**			
Email:					

Primary Care Physician Name:	☐ NONE
PCP Practice Name:	
Emergency Contact Name:	
Relationship to Patient:	☐ Mother ☐ Father ☐ Other (specify):
Emergency Contact Phone:	

RESPONSIBLE PARTY (If self, check *self* , and skip to next section.)					
Relationship to Patient:	☐ Self ☐ Mother ☐ Father ☐ Other (specify):				
Last Name:		**First Name:**		**MI:**	
SSN:		**Gender**	☐ M ☐ F	**Date of Birth:**	
Address:					
Email:					

SUBSCRIBER INFORMATION (If self, check *self* , and skip to next section.)			
Relationship to Subscriber:	☐ Self ☐ Mother ☐ Father ☐ Other (specify):		
Subsciber Name:			
Subscriber Date of Birth:		**Subsciber SSN:**	
Subscriber Address:			

INSURANCE INFORMATION			
Insurance Company:			
Group Name:		**Group Number:**	
Member ID:			
Plan Type:	☐ PPO ☐ POS ☐ HMO ☐ EPO ☐ Indemnity ☐ Other:		
Medical Claims Address:			

ANNUAL CONSENT FORM

Piedmont Urgent Care BY WellStreet

Release of Medical Information & Records Consent:

Piedmont Urgent Care by WellStreet (PUCBW) may want to contact you by phone or email with information such as lab or x-ray results, follow-up post visit, or instructions from your doctor. We can leave detailed medical information on your voicemail with your consent.

Please list the best phone number and email we may leave messages with detailed medical information.

Phone: _____ **Type:** ☐ Cell ☐ Home

☐ I do not consent to messages being left on my voicemail regarding my care.

Email: _____

☐ I do not consent to emails regarding my care.

Please list a representative of your choice we may disclose medical information including record release.

Last Name: _____ **First Name:** _____

Relationship: _____

☐ I do not consent to messages or disclosure of medical information with anyone other than myself.

Consent for Treatment:

Patient consents to the rendering of Medical Treatment/Services as considered necessary and appropriate by the attending physician or other practitioner, a member of the PUCBW medical staff who has requested care and treatment of Patient, and others with staff privileges at PUCBW. Medical Treatment/Services may be performed by "Healthcare Professionals" (physicians, nurses, technologists, technicians, physician assistants, or other healthcare professionals). Patient authorizes the attending or other practitioner, the medical staff of PUCBW and PUCBW to provide Medical Treatment/Services ordered or requested by attending or other practitioner and those acting in his or her place. The consent to receive "Medical Treatment/Services" includes, but is not limited to: urgent care; examinations (x-ray or otherwise); laboratory procedures; medications;infusions;drugs;supplies; anesthesia; surgical procedures and medical treatments; recording/filming for internal purposes (i.e. Identification, diagnosis, treatment, performance improvement, education, safety, security) and other services which Patient may receive. In the event PUCBW determines that Patient should provide blood specimens for testing purposes in the interest of the safety of those with whom Patient may come in contact; Patient consents to the withdrawing and testing of Patient's blood and to the release of test information where this is deemed appropriate for the safety of others.

Financial Responsibility:

I understand it is the responsibility of each patient to arrange for payment for the medical services received in this office. I hereby authorize any insurance benefits to be paid directly to Piedmont Urgent Care by Wellstreet, and recognize my responsibility to pay for all non-covered services, including out of network insurance expenses. An attempt will be made to verify all insurance at the time of service for each visit. I also authorize the release of any information necessary to process an insurance claim. Charges for all minors are the responsibilty of the parent, guardian, or individual presenting the child for treatment.

Consent to Obtain Medical Records:

I hereby authorize Piedmont Urgent Care by WellStreet to obtain medical records from any other physician or medical facility necessary in the course of my treatment.

Patient Survey

Patient authorizes Piedmont Urgent Care by Wellstreet and/or its authorized representative to contact Patient after discharge for the purpose of conducting patient satisfaction surveys and other studies.The patient satisfaction survey may be delivered via email, text and/or phone. By signing the agreement you are approving all methods and understand an opt-out option will be available after delivery if you wish to discontinue using the survey service.

Acknowledgement of Privacy Rights:

By signing below I acknowledge that I have received the Piedmont Urgent Care by WellStreet notice of Privacy Practices and Individual Rights.

I acknowledge that I have read the above, am giving my consent to the above, and have been informed of my rights to privacy.

Print Patient Name **Signature** **Date**