Beaumont Urgent Care BY WellStreet

2021 Registration Form

PATIENT INFORMATION					
Last Name		**First Name**		**Middle Initial**	
Preferred Name		**Sex**	☐ Female ☐ Male	**Date of Birth**	
Address					
City		**State**		**Zip code**	
Primary Phone		**Email Address**			
Emergency Contact		**Emergency Phone**			

Beaumont Urgent Care by WellStreet (BUCBW) 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 check here if you DO NOT consent to voicemail on the Primary Phone or Email regarding your care
☐ **I DO NOT wish to consent to voicemail or email regarding my care**

Primary Care Physician (PCP)	☐ **NONE**	**PCP Phone**	
PCP Practice/Hospital Association			

RESPONSIBLE PARTY (If self, skip to next section)					
Last Name		**First Name**			
Date of Birth		**Email Address**			
Insurance Company		**Member ID**		**Group Number**	
Medical Claims Address *(found on back of card)*					
Secondary Insurance Company *(if applicable)*		**Member ID**		**Group Number**	
Secondary Insurance Medical Claims Address					

SUBSCRIBER INFORMATION (If self, check *self,* and skip to next section)			
Relationship to Subscriber	☐ **Self** ☐ **Mother** ☐ **Father** ☐ **Spouse** ☐ **Other (*Specify*):**		
Last Name		**First Name**	
Subscriber Date of Birth		**Subscriber SSN**	

PLEASE LIST REPRESENTATIVE/S OR ENTITY OF YOUR CHOICE WE MAY DISCLOSE MEDICAL INFORMATION, INCLUDING MEDICAL RECORDS			
Last Name		**First Name**	
Phone		**Relationship**	

Conditions of Service and Consent to Treat

PLEASE DO NOT SIGN THIS FORM WITHOUT READING THE ENTIRE CONTENT

By submitting this Consent Form (the "Conditions of Service and Consent to Treat") and agreeing to the Terms and Conditions set out herein, you ("you", "your", "undersigned representative acting on behalf of the Patient") provide your consent to the following:

Consent to Routine Medical Treatment/Services

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 BUCBW medical staff who has requested care and treatment of Patient, and others with staff privileges at BUCBW. 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 BUCBW and BUCBW to provide Medical Treatment/Services ordered or requested by attending or another 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 BUCBW 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.

Authorization to Release Information

BUCBW is authorized to use and release information contained in the patient record as described in the BUCBW Notice of Privacy Practices and as otherwise permitted or required by law. The information authorized to be used or released will include, but is not limited to, infectious or contagious disease information, including HIV or AIDS-related evaluations, diagnosis or treatment, information about drug or alcohol abuse or treatment of same and/or psychiatric or psychological information. Patient waives any privilege pertaining to such confidential information and hereby releases BUCBW, its agents and employees from all liabilities, responsibilities, damages, claims, and expenses arising from the use and release of information as authorized above. Permissible uses and disclosures include, but are not limited to, disclosures to insurance companies, their agents or other third party payors and/or government or social service agencies that may or will pay for any part of the medical expenses incurred or authorized by representatives of BUCBW. **PATIENT ACKNOWLEDGES AND AGREES THAT PATIENT'S RECORDS WILL BE AVAILABLE TO ALL BUCBW AFFILIATED ENTITIES AND PROVIDERS, AND TO NON-BUCBW AFFILIATED REFERRING PROVIDERS IN COMPLIANCE WITH THE PROVISIONS OF MEANINGFUL USE**. By consenting to treatment and accepting financial responsibility for any such treatment, Patient also understands and acknowledges that BUCBW, may send Patient Satisfaction surveys, email, call and/or text the phone number Patient has provided with treatment-related information and patient financial responsibility balances.

Patient Financial Responsibility

Patient acknowledges they are financially responsible for any out-of-pocket expenses for medical services and treatment including copayments, coinsurance, deductibles, and services not payable by the patient's health plan. Co-payments are due at time of service. Patient agrees to obtain any necessary referrals prior to visit. Charges for all minors are the responsibility of the parent, guardian, or individual presenting the child for treatment. Patient acknowledges agreement to pay for all medical services and treatment provided at time of service if payment type is self-pay. Patient acknowledges medical services/treatment will be self-pay if active insurance information is not provided within 24 hours of medical services and treatment.

Acknowledgement of Patient Rights and Privacy Practices

By signing below, I acknowledge that I have received the Beaumont Urgent Care by WellStreet **Patient Rights and 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.

Printed Patient Name: _____

Signature of Patient or Parent/Guardian: _____ **Date:** _____