



15215 Shady Grove Rd. # 100
Rockville, MD 20850
(301) 519-0902
Fax (301) 519-0905

AUTO ACCIDENT INFORMATION

Date: _____ Time: _____ Reason for Visit: _____

PATIENT REGISTRATION INFORMATION

Patient Name: _____
Last First MI

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Primary Doctor: _____ Primary Doctor's Phone#: _____ Your Date of Birth: _____

Sex: Female Male Marital Status: Single Married Separated Divorced Widowed Social Security #: _____ - _____ - _____

EMERGENCY CONTACT

Name: _____ Relationship to patient: _____
Last First MI

Home Phone: _____ Cell Phone: _____

ADDITIONAL INFORMATION

Race: African American or Black American Indian Asian Caucasian or White Hispanic Native Hawaiian or Pacific Islander Other

Ethnicity: Hispanic or Latin American Non-Hispanic or Other Email: _____ @ _____

Electronic prescription notice: **PLEASE CHOOSE ONLY ONE**

- I authorize Physicians Now, LLC to access my prescription history
- I do not authorize Physicians Now, LLC to access my prescription history

Send my prescriptions to:

Pharmacy: _____ City: _____ Cross Street: _____

Please **INITIAL** lost prescription policy:

_____ I understand that if I lose or misplace my prescription I will not receive another one without being re-evaluated.

How did you hear about us? _____

AUTO ACCIDENT CARRIER

Auto Compensation Carrier: _____

Carrier Address: _____ Adjuster's Name: _____

Adjuster's Phone #: _____ Claim #: _____

Coverage Verified by: _____

ACCIDENT INFORMATION

Date of Injury: ____/____/____ Time: _____ AM PM Body part of injury: _____

Accident reported to insurance? Yes No Name of person you reported accident to: _____

Is there a police report? Yes No

Give full description of how accident happened: _____

Have you lost time from work? Yes No How much? _____

Other doctors seen for this condition? Yes No Doctor's Name? _____

Were X-Rays taken? Yes No Other tests? Yes No If yes to either, by whom? _____

Please list name of test(s) and result(s) _____

The above information is true to the best of my knowledge. I authorize Physicians Now to apply for benefits on my behalf for covered services rendered by Physicians Now, and I request my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Physicians Now or the insurance company to release any information required to process my claim. I understand that my records and medical information may be shared with my employer when that employer has requested the services provided. I consent for treatment by the patient care staff at Physicians Now and acknowledge that no guarantee can be made concerning the results of that treatment. I acknowledge that the Notice of Privacy Rights (HIPPA) has been made available to me.

Patient/Guardian Signature: _____ Date: _____



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Patient Financial Policies

To reduce confusion and misunderstanding between our patients and practice, we adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made, in advance, by either you or your health insurance carrier, full payment is due at the time of service. For your convenience, we accept cash and the following major credit/debit cards: VISA, MASTER CARD and DISCOVER.

Minor Patients: For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

Uninsured/Cash patients are required to pay a \$120 deposit prior to being seen, which will apply to your office visit.

Physicians Now, LLC charges a billable urgent care fee (S9088). This may or may not be covered by your insurance.

Your insurance: Please INITIAL the following showing that you understand and accept our financial policy.

_____ *We will verify your insurance benefits to the best of our ability via internet or customer service lines. Some Insurances cannot be verified after hours or on weekends. Additional payment may be due after your insurance company processes your claim according to your benefits.

_____ *In the event we cannot verify your insurance benefits while you are in our office or if you have insurance coverage with a plan that we do not take; we will expect payment in full at time of service.

_____ *By signing this form, you authorize Physicians Now Urgent Care to bill your credit/debit card on file for any balance your insurance company deems to be your responsibility per the Explanation of Benefits (EOB). A courtesy call will be made to the credit/debit card holder if the balance due is greater than \$100. We do not send out statements. The alternative to leaving a credit/debit card on file, is to pay in full at the time the services are rendered. The patient will be refunded when Physicians Now Urgent Care receives payment from the insurance company.

Check one: Visa MasterCard Discover

Last 4 digits of my credit/debit card: _____ Exp. Date (mm/yy): _____

- Declined transaction/closed account:

A \$50 penalty will be added to all accounts if no alternative payment is provided.

Would you like an e-mailed receipt? Yes No E-mail: _____

- Delete my credit/debit card information once my claim has been processed and paid.

Note: A new agreement will be needed for each subsequent visit.

- Leave my credit/debit card information on file for my future visits.

_____ * **Unpaid Balance: Past due accounts are subject to a \$25.00 monthly late fee. Payments not received within 60 days of statement date will be sent to the collection agency and/or attorney.** If you are unable to pay the balance due in full, you must contact our billing office to discuss possible payment options. You can submit payments over the phone at (240) 654-3951 and online at www.myphysiciansnow.com. If your statement balance is paid by check and the check is returned unpaid by your bank for any reason, a \$50.00 returned check fee will be added to your account.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time. In the event the account must be turned over to an attorney or collection agency, you shall be responsible for all attorney and collection agency fees incurred. If your account is assigned to a professional collection agency, you will no longer be able to receive services from the providers at Physicians Now Urgent Care until your balance is paid in full.

I have read, understand and agree with the PNUCC financial policy.

Patient or authorized person signature

Date

Management Only: AWOCOF _____ PTSTCCOF _____ CRBCCOF _____ Other _____



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Acknowledgment of Review of Notice of Privacy Practice

Please **INITIAL:**

_____ I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.
I understand that I am entitled to receive a copy of this document.

Request for Protected Health Information

You have my permission to discuss my medical care/account with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Please indicate where it is OK to leave you a detailed sensitive message: (Please Check all that apply)

- HOME WORK CELL

E-MAIL POLICY

It is generally a policy of this office not to communicate Protected Health Information (PHI) and Health Insurance Portability and Accountability (HIPAA) sensitive information through email. However, we know in certain situations, it may be the only form of communication available. E-mail communications from our office are NOT secure and thus are not HIPAA compliant. Unsecured e-mail is at risk of being intercepted by an unauthorized third-party. To email PHI and HIPAA sensitive information through an unsecured channel, we need your informed consent. Even with consent, Physicians Now Urgent Care reserves the right to use other forms of communication if we deem warranted.

Exception to this policy:

We do not send sensitive lab results through email. They must be picked up in person or through a visit with a provider.

Please **INITIAL ONLY ONE** selection:

_____ Physicians Now, LLC has made me aware of the risks associated with sending PHI through unsecured e-mail. I **give** my consent to have PHI e-mailed to me despite the risk.

_____ Physicians Now, LLC has made me aware of the risks associated with sending PHI through unsecured e-mail. I **DO NOT give** my consent to have PHI e-mailed to me.

Email Address: _____

X _____
Print Patient Name

Patient DOB

X _____
Signature of Patient, Parent or Guardian

Date



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Assignment of Benefits to: Physicians Now Urgent Care

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled, to Physicians Now LLC. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Physicians Now LLC for services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for all amounts not covered by insurance.

I _____(patient name) hereby assign to the Health Care Provider indicated above all rights, privileges, and remedies to payment for health care services provided by Physicians Now LLC to which I am entitled under the insurance law. Physicians Now LLC certifies that they have not received any payment from me, or on behalf of me, and shall not pursue payment directly from me for services provided by Physicians Now LLC for injuries sustained due to the motor vehicle accident.

This agreement may be revoked by Physicians Now LLC when benefits are not payable based upon lack of coverage and/or violation of a policy condition due to the actions or conduct.

Authorization to Release Information

I hereby authorize Physicians Now LLC to: (1) release any information necessary to insurance carriers regarding my illness and treatment; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Physicians Now LLC on behalf of myself and/or my dependents. I understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/ Responsible Party Signature

Date

Witness

Date

Insurance Name

Insurance ID#/ Claim #