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

Date:_____ **Time:**_____ **Reason for Visit:**_____

EXISTING PATIENT REGISTRATION INFORMATION

Patient Name:_____
Last First MI

Address:_____
Street City State Zip

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

Date of Birth: _____/_____/_____ **Social Security #:**_____-_____-_____

Marital Status: _____ **Email Address:** _____

Primary Doctor:_____ **Primary Doctor's Phone #:**_____

INSURED AND/OR PARENT/GUARDIAN INFORMATION

Name of your primary insurance:_____

Phone Number:_____

Address:_____
Street City State Zip

Subscriber Name: _____ **Date of Birth:** _____/_____/_____

Subscriber ID: _____ **Group number:** _____

ADDITIONAL INFORMATION

Pharmacy: _____ **Pharmacy Phone #:** _____

Electronic Prescription Notice: **PLEASE CHOOSE ONE OPTION BELOW**

❑ I authorize Physicians Now, LLC to access my prescription history.

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

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.

Physicians Now
URGENT CARE
You Matter. We Care.

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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: ❑ AWOCCOF_____ ❑ PTSTSCCOF_____ ❑ CRBCCOF _____ ❑ Other_____