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

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 #:_____-_____-_____

Employer Name: _____ Occupation: _____

INSURED AND/OR PARENT/GUARDIAN INFORMATION

Relationship to the Insured ❑ Self ❑ Spouse ❑ Child ❑ Other_____ Name of your primary insurance:_____

Insured Name:_____Insured DOB:_____Insured SS #:_____-_____-_____
Last First MI

Address (If different from above):_____
Street City State Zip

Secondary Insurance: ❑ Yes ❑ No

Relationship to the Insured ❑ Self ❑ Spouse ❑ Child ❑ Other_____ Name of your secondary insurance:_____

Insured Name:_____Insured DOB:_____Insured SS #:_____-_____-_____
Last First MI

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 E-mail:_____@_____

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 PHYSICIAN'S NOW? Please check one below:

❑ Friend/family ❑ Provider _____ ❑ Health Insurer _____

❑ Online - Google, Yelp, ZocDoc, Facebook, other ❑ Building signage/driving by ❑ Company/business_____

❑ Apartment/Housing Welcome Package_____ ❑ Other_____

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: _____

Physicians Now
URGENT CARE
You Matter. We Care.

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

Explanation of Self-Pay Service Fees

Physicians Now Urgent Care Center (PNUCC) understands that illness or injuries are unplanned and sometimes may occur during difficult economic times. For this reason, PNUCC offers a 25% discount off our regular fees to un-insured patients.
Below is an example of the discounted fee.

Medical consultation fee	Reg. charge	25% off	You pay
Consultation with our health care provider starts at: Basic	$160.00	$40.00	$120.00
Level 4 visit: high medical complexity	$250.00	$62.50	$187.50
Level 5 visit: higher medical complexity	$320.00	$80.00	$240.00
Critical care visit: Highest medical complexity	$500.00	$125.00	$375.00

Labs, x-rays, supplies, medications, and/or procedures are also discounted at 25% from the regular charges. Please note, because it is difficult to accurately estimate the exact charges for our services prior to being examined by our health care provider, the best estimate is obtained after the evaluation by our health care provider. For this reason, you will be apprised of any potential change(s) in levels of care for your consent, before treatment commences, except in life or organ threatening conditions where stabilizing the patient is our utmost priority.

- *Consultation fees are non-refundable.*
- *All charges are due at the time of service.*
- *In rare instances you may receive an additional bill after your visit if the billing department discovers any of the following after your visit while processing your chart:*
  - *Omitted supplies or procedures - improperly billed level of care*
  - *Other circumstances not mentioned herein*
- *We will process a refund if we discover that you were accidentally overcharged for your visit.*
- *Overdue accounts will be assessed a monthly finance charge of 3% of the balance.*

***Exclusions:** Some high risk medical conditions start at level 4 consultation fee even if no labs, x-ray or treatments are performed at the time of service. This is because they require in-depth evaluation and/or higher level of medical decision making. Examples of such visits, although not an all-inclusive list are:

- Motor vehicle accidents, fall from heights, head injuries, headaches, asthma attacks, chest pains, abdominal pains, GI bleed, vaginal bleed, shortness of breath, palpitations, dizziness, std testing, etc.

I have read, understand and agree to PNUCC self-pay policy.

Patient or authorized person

Date

** Our health care provider is a licensed Physician, Physicians Assistant, or Nurse practitioner**

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

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**