Physicians Now URGENT CARE
You Matter. We Care.

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

PATIENT REGISTRATION FORM

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:** _____

CONTRACTED COMPANY: Please choose one

- ❑ The Arc Of Montgomery
- ❑ Best Tile
- ❑ Calleva
- ❑ Drinkmore Water
- ❑ Gaines & Company
- ❑ Henry Schein Prorepair
- ❑ The Universities At Shady Grove
- ❑ Talk Of The Town Entertainment
- ❑ Telligent Masonry Construction
- ❑ Work Well
- ❑ Other: _____

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 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:** _____

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Financial Policy

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 card/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.

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

_____ Please note your employer has an agreement in place with Physicians Now Urgent Care Center (PNUCC) to provide occupational services to you. We will bill your employer according to the contract terms. In the event, your employer denies and/or does not make payment for services you were rendered in a timely manner, you will be responsible for the whole bill.

_____ 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_____

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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**