Physicians Now URGENT CARE
You Matter. We Care.

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

WORKERS COMPENSATION INFORMATION

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

Employer Name:_____ **Employer Phone #:**_____

Employer Address:_____

Contact Person:_____

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:

- ❑ **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?_____

WORKER COMPENSATION CARRIER

Worker Compensation Carrier:_____

Carrier Address:_____

Adjuster's Name:_____ **Claim #:**_____

Adjuster's Phone #:_____

INJURY INFORMATION

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

Accident reported to employer? ❑ Yes ❑ No **Name of person you reported accident to:**_____

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)_____

_____

Any previous Worker Compensation injuries? ❑ Yes ❑ No **Date(s) of previous injuries?**_____

Describe previous Worker Compensation injuries_____

_____

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: ❑ 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**