Physicians Now
URGENT CARE
You Matter. We Care.

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

Employer Name: _____ Occupation: _____

INSURED AND/OR PARENT/GUARDIAN INFORMATION

Name of your **primary insurance**: _____

Relationship to the Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insured Name: _____ Insured DOB: _____
Last First MI

Address (if different from above): _____
Street City State ZIP

Secondary Insurance: ☐ Yes ☐ No Name of your **secondary insurance**: _____

Relationship to the Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insured Name: _____ Insured DOB: _____
Last First MI

EMERGENCY CONTACT

Name: _____ Relationship to patient: _____
Last First MI

Home phone: _____ Cell Phone: _____

ADDITIONAL INFORMATION

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 (HIPAAA) 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 cards: VISA, MASTERCARD, DISCOVER and AMEX.

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 of payment.

Uninsured/Cash patients are required to pay an initial consultation starting rate of $150.00 deposit prior to being seen, which will apply to your office visit.

Physicians Now, LLC charges a billable urgent care fee code S9088. This may or may not be covered as per allowed 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 that your insurance benefit is discovered to be inactive on the time of service you will be responsible for visit charges at a self-pay rate.

_____ By signing this form, you authorize Physicians Now Urgent Care to bill your credit card on file for any balance your insurance company deems to be your responsibility per Explanation of Benefits (EOB). A courtesy call will be made to the credit card holder if the balance due is greater than $100.00. We no longer mail out statements.

Check one: ☐ Visa ☐ MasterCard ☐ Discover ☐ AMEX

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

- Declined transaction/Closed account:

  A $50.00 penalty will be added to all accounts if no alternative method is provided.

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

_____ ***Unpaid Balance: Past due accounts are subject to a $25.00 monthly rate 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 in full, you must contact our billing office to discuss possible payment options. You can submit payments over the phone at 865-293-4872 or 865-722-7492 or online at https://physiciansnow.securepayments.cardpointe.com/pay. 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 term. I also understand and agree that the practice may amend such term 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 collections 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 self-pay policy.

_____ _____

Patient or authorized person signature Date

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Acknowledgment of Review of Notice of Privacy Practice

Please INITIAL policy:

_____ 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/FAX WAIVER 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 e-mail. 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 despite the risk.

Email Address: _____

_____ _____
Print Patient Name **Date**

_____
Signature of Patient, Parent or Guardian