



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

AUTO INSURANCE FORM

PATIENT REGISTRATION INFORMATION

Patient Name: _____ Date of Birth: _____
Last First MI
Home Phone: _____ Cell Phone: _____ Work Phone: _____

EMERGENCY CONTACT

Name: _____ Relationship to patient: _____
Last First MI
Home Phone: _____ Cell Phone: _____

AUTO INSURANCE INFORMATION

Auto Insurance 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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www.myphysiciansnow.com

Patient Financial Responsibilities:

Thank you for choosing Physicians Now Urgent Care for your medical needs. We are committed to providing you with the highest quality of healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Copays are due at the time of service.
- Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.
- Patients may incur, and are responsible for payment of additional charges, if applicable.
- You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to pursue the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.
- By my signature below, I hereby authorize assignment of financial benefits directly to Physicians Now Urgent Care and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Patient name: _____

Patient or authorized person signature: _____ **Date:** _____