



DUKE CITY URGENT CARE

PATIENT REGISTRATION FORM NEW

11601 Montgomery Blvd. N.E.
Albuquerque, NM 87111-2660
(505) 814-1995

PATIENT INFORMATION

Reason for Visit _____

Patient's Full Name _____ Ethnicity: Caucasian ___ African American ___ Asian ___ Pacific Islander ___ Native American ___ Hispanic/Latino ___

Last Name _____ First Name _____ MI _____ Age _____

Social Security # _____ - _____ - _____ Date of Birth MM/ DD/ YYYY Sex: Male Female

Mailing Address _____ City _____ State _____ Zip Code _____

Home phone: (____) _____ - _____ Alternate/Cell phone: (____) _____ - _____ Email _____

Marital Status: Single Married Widowed Divorced Spouse's Name _____

Emergency Contact Name _____ Telephone Number (____) _____ - _____ Relation: _____

Primary Care Physician _____ Telephone Number (____) _____ - _____

Primary Insurance _____ Policy Holder _____

Policy Holder: Date of Birth _____ Social Security # _____ Relationship to Patient _____

Secondary Insurance _____ Policy Holder _____

Policy Holder: Date of Birth _____ Social Security # _____ Relationship to Patient _____

* Is Patient under 18 years of age Yes No (If yes, please complete below)

Parent/Guarantor Name _____ Relationship to Patient _____

Mailing Address (only if different from patient address) _____

City _____ State _____ Zip Code _____ Telephone Number (____) _____ - _____

How did you hear about us? _____

CONSENT FOR MEDICAL TREATMENT

I hereby consent to the procedures which may be performed during this examination, including services which may include but are not limited to laboratory procedures, x-ray examination, diagnostic procedures, medical, and/or surgical treatments or procedures, anesthesia or other urgent services rendered to me under the general and special instruction of a Duke City Urgent Care Provider.

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received the notice of privacy practices, which describes the ways in which Duke City Urgent Care may use and disclose my healthcare information for treatment, payment of services, healthcare operations and other described and permitted uses and disclosures.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize the payment directly to Duke City Urgent Care, LLC for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for any and all charges not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I further acknowledge that I have received and read the financial policy for Duke City Urgent Care. I understand and agree to the financial policy.

FINANCIAL AGREEMENT

In consideration of the services rendered to the patient, the undersigned (as parent, guardian, spouse, guarantor, and agent or as the patient) individually promises to pay the patient's account at the rates established by the clinic for services provided. A receipt of charges for services to the patient is available upon request. All final charges are based on multiple factors, including but not limited to the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services.

I hereby consent, acknowledge and fully understand the above. I also understand there are no guarantees or assurances from anyone as to the results that may be obtained from any medical treatment or services rendered at Duke City Urgent Care.

Signature of Patient/Guarantor: _____ Date: _____



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For office use only

Documentation of Good Faith Efforts

To obtain patient's acknowledgement that they received provider's Notice of Privacy Practices

For use when acknowledgement cannot be obtained from the patient.

The patient presented to the clinic on _____ and was provided with a copy of Duke City Urgent Care's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

Patient refused to sign

Patient had a medical emergency

Other reason (describe below)

Employee Name (Print)

Signature

Documentation of Good Faith Efforts
Notice of Privacy Practices