WINDING CROSS URGENT CARE OF FREDERICK

PATIENT REGISTRATION FORM

Monocacy Emergency Physicians
T/A Winding Cross Urgent Care of Frederick
Thank you for Choosing our Facility

Date: _____

Patient #: _____
Office Use Only

PATIENT INFORMATION:

Last: _____ First: _____ MI: ____

Social Security #: _____

Address: _____

_____
City State ZIP

Date of Birth: _____

Sex: Male / Female Race: _____

Email: _____

Marital Status: Single / Married / Separated / Divorced / Widowed

Home Phone: _____

Work Phone: _____

Cell Phone: _____

PRIMARY SUBSCRIBER INFORMATION:

Primary Insurance: _____

Last: _____ First: _____ MI: ____

Social Security #: _____

Date of Birth: _____

Patient ID Number: _____

Group #: _____

Relationship to Subscriber: _____

SECONDARY SUBSCRIBER INFORMATION:

Secondary Insurance: _____

Last: _____ First: _____ MI: ____

Social Security #: _____

Date of Birth: _____

Patient ID Number: _____

Group #: _____

Relationship to Subscriber: _____

Responsible Party: (only if patient under age of 18)

Last: _____ First: _____ MI: ____

Social Security #: _____

Address: _____

_____
City State ZIP

Date of Birth: _____

Race: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Employment Information:

Employed at: _____

Address: _____

_____
City State ZIP

Patient's Primary Care / Referring Physician:

Last: _____ First: _____

Office Phone: _____

Emergency Contact Person:

Name: _____

Phone #: _____

Relationship: _____

How Did You Hear About Us?

Doctor	Frederick Fair	Frederick Magazine
Friend / Family	Internet	Find It Frederick
Sign	Tots2Tweens	

Other: _____

WINDING CROSS URGENT CARE OF FREDERICK

Consent Form

Monocacy Emergency Physicians T/A Winding Cross Urgent Care of Frederick

Patient #: _____

Patient: Last Name: _____ First Name: _____ MI: _____

Patient: D.O.B.: _____ Email: _____

Reason for Visit: _____

Patient Phone: _____ Date of Onset: _____ Injury or Illness? _____

Is this visit related to Motor Vehicle or Work Accident? _____ If yes, please notify receptionist.

Patient Address: _____ Responsible Party address (if different from patient)

_____ _____

City State ZIP City State ZIP

MEDICAL CONSENT:

- I consent to the medical care provided during this visit.
- I have the right to make informed decisions about my healthcare, including the refusal of treatment or procedures.
- I have reviewed and consent to the HIPPA/ Notice of Privacy Practices policy provided for me.

FINANCIAL AGREEMENT:

To file your insurance claim, a valid/up to date insurance card MUST be present at time of service.

- I direct all payments for medical services provided at this facility to be paid to Monocacy Emergency Physicians T/A Winding Cross Urgent Care of Frederick. I understand that this facility has the right to refuse to accept this direction. If these payments are made directly to me, I agree to forward these health insurance payments to this facility.
- I understand that if tests are to be sent to a reference laboratory for further testing that I may receive an additional bill from that company.
- I understand that not all procedures, tests, and DME supplies may be covered by my insurance plan. I acknowledge that I will be financially responsible for any balance.
- If my account balance becomes 30 days past due, I understand that I will be charged a 2% finance charge every billing cycle until the balance is paid in full.
- If my account becomes assigned to a collection agency, I agree to pay the collection fee of 35% and all court costs, and attorney fees. I also consent to be contacted by any information that I have provided.
- I understand that if a referral or pre-authorization is needed, but not obtained, I am responsible for full payment for all services rendered.
- I understand that if my eligibility for insurance coverage cannot be confirmed at this time AND it is later determined that I am not eligible for coverage; I will be responsible for payment of all services provided.
- Co-pays collected are for specialists unless otherwise stated, however, if amount is more, you will receive a bill for the remainder of co-pay. Refunds are issued at the beginning of each month.

CREDIT CARD AUTHORIZATION:

- I authorize you to charge my debit/credit card on file for any past due balance greater than 30 days.

By signing below I consent to all of the above:

Patient Signature: _____ Initials: _____ Date: _____ Time: _____ AM/PM

_____ _____ _____

Responsible Party Signature (if patient less than 18) Relationship Witness (WCUC Representative)