Please complete all sections of this form.

Please alert a staff member IMMEDIATELY if you are experiencing any of the following: CHEST PAIN, SHORTNESS OF BREATH, FACIAL DROOPING, SLURRED SPEECH AND/OR A TEMPERATURE ABOVE 101 DEGREES F. or if you are pregnant or think you may be pregnant.

A: Demographics

First Name:________________________ Last Name:________________________ MI:________

Birthdate:_______________ SSN:____________________ **required* Gender: Male or Female

Address:______________________ City:_______________ ST:_________ Zip Code: _____________

Home Phone:____________ ☐OK to leave message Cell Phone:__________________ ☐OK to leave message

Email:____ Marital Status: ________________

Race:_________________ Ethnicity: Hispanic or Non-Hispanic Preferred Language: ____________________

Employer: _____________________ Title: __________________ Employer Phone: _________________

Primary Care Physician:____________________ Phone:__________________ Fax: _________________

Emergency Contact:___________________ Phone:_________________ Relationship: _______________

Reason for today's visit: ____

Medications:____ OR ☐See attached list

☐ Medication Allergies: ____

☐ Allergies:____

☐ **Preferred Pharmacy Name** __________________ Address ___________________ Zip______________

☐ How did you hear about us? ____

Parent/Guardian if patient is under 18 years old.

Name:____________________________________ Relationship: ________________________

SSN of Guardian:________________ **required* Birthdate_______________ **required* Phone: ______________

Section B continues on back

B: Insurance

*We cannot accept any Ohio Medicaid plans, including CareSource, Molina, Buckeye Health Plan, Paramount Advantage and United Healthcare Community Plan of Ohio.

☐I do not have private health insurance: If you do not have private health insurance skip to section C.
☐THIS IS A WORK RELATED INJURY. (Please alert the receptionist. You must provide health insurance for work related injuries)
☐This is the result of a motor vehicle accident. You must also provide health insurance information. If you do not have health insurance you will be required to pay as a self-pay patient. If the motor vehicle insurance covers your visit all applicable payments will be refunded.

Primary Insurance:_______________________________________Co-Pay:____________________
Insured Name:____________________________Relationship to patient:______________________
Birthdate:____________________**required* SSN:______________________________**required*
Gender: Male or Female Phone: ______________________________
Insured Address:_____________________City:__________ST:______Zip Code:____________
Secondary Insurance if applicable:__________________________Co-Pay:__________________
Insured Name:____________________________Relationship to patient:______________________
Birthdate:____________________**required* SSN:______________________________**required*
Gender: Male or Female Phone: __________________________________
Address:__________________________City:___________ST:______Zip Code: ________

C: Acknowledgement of Arlington Urgent Care Notice of Privacy Practices

- I hereby acknowledge that I have reviewed, received, or have been given the opportunity to receive a copy of Arlington Urgent Care, Inc.'s Notice of Privacy Practices (attached to clipboard).
- I have read, understand, and agree to the attached Financial Policy. I am aware that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.
- I authorize my insurance benefits be paid directly to Arlington Urgent Care, Inc.
- I authorize Arlington Urgent Care, Inc. through its appropriate personnel, to perform upon me, or the above named patient, appropriate assessment and treatment procedures.
- I authorize Arlington Urgent Care, Inc to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.
- I agree to have my insurance, or self, charged for all services utilized by an outside facility including, but not limited to, laboratory analysis.
- I expressly consent and agree that, in order to discuss or service your accounts(s) (the "Accounts ") or to collect amounts I may owe, Arlington Urgent Care, Inc. and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively, "We") may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contact you by sending text messages, emails, using any e-mail address you provide to us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

Patient/Guardian Signature:_______________________________________Date: ____________________

CREDIT CARD AUTHORIZATION

Date of Service (Today's Date): _________________

Arlington Urgent Care, Inc. submits claims to insurance carriers as a convenience to all our patients. At this time, we request authorization to balance bill a major credit/debit card to cover amounts determined by your insurance to be your responsibility. These amounts may be due to unpaid portions of deductibles, co-pays, co-insurances or in the event of a non-covered service.

Upon receipt of an explanation of benefits (EOB) from your insurance carrier any unpaid portion of your claim will be billed to your credit/debit card. Should insurance pay in full, your account will not be charged.

This authorization is valid only for ninety days from the Date of Service listed above and will not qualify for any past or future visits.

All credit/debit card information will remain absolutely confidential and securely stored by **First Data,** one of the world's largest merchant services provider. Arlington Urgent Care, Inc. will not store any banking account data.

Please complete the information below:

I _________________________ authorize Arlington Urgent Care, Inc. to charge my credit card account for the total fees owed by me, such as fees applied to copays, deductibles, or co-insurances, not to exceed $150.00.

I hereby authorize Arlington Urgent Care, Inc. to charge any and all outstanding balances for the date of service listed above, after insurance company reimbursement or denial, up to $150.00 to my credit card. I understand that I will not receive a statement if there is no balance due after processing my credit card for payment.

____ ______________________

Cardholder's Authorization Signature **Date**

____

Email