EXPRESS CARE Of Ocala
The ER Alternative

REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Martial status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	Is not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Mailing address:(Where you receive your mail)	Social Security no.:	Home phone no.: ( )	Cell phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Choose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Email address to access Patient Portal:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this person covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ BC/BS	❑ Medicare	❑ Medicaid	❑ United Healthcare	❑ Workers Comp

❑ Auto Insurance ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Express Care of Ocala or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

PLEASE READ: ALL PAYMENTS, UNMET DEDUCTIBLES AND CO-PAYMENTS DUE AT TIME OF REGISTRATION.

INSURANCE AUTHORIZATION AND ASSIGNMENT AND CONSENT OF TREATMENT

Name of Beneficiary_____ HIC Number_____

I request that payment of authorized Medicare benefits be made on my behalf to Express Care of Ocala for any servicesfurnished me by that physician. I authorize any holder of medicare information about me to release to the Health Care Administration and it's agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the informationto the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge, andthe patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and thedeductible are based upon the charge determination of Medicare.

I understand all professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments, however, the patient is ultimately responsible for all fees, regardless of insurance coverage. All fees still pending with insurance companies after sixty days will be the responsibility of the patient.

I understand there will be a $25 dollar fee for all accounts turned over to a collection agency and/or returned checks.

I understand I may receive a bill from an outside laboratory for any laboratory work done off premises. Express Care of Ocala does not have any financial interest in any outside laboratories.

Signature_____ Date_____

Reason for your visit: _____

CONSENT FOR TREATMENT

I certify that the above information is correct on this date. I hereby give Express Care of Ocala's medical providers permission to treat me or my ward. I understand that emergency or urgent care only is provided, and no responsibility will be taken for long term patient care after normal office hours except in those cases under contract with Medipass where in the patient is assigned to ECO as a primary care patient.

DATE	TIME	SIGNATURE	DATE	TIME	SIGNATURE