HealthNow Primary + Urgent Care

"Better health now & wellness for life"

2086 Gulf to Bay Blvd | Clearwater, FL 3376 |Phone: (727)462-010 | Fax: (727)462-0177
7599 Park Boulevard| Pinellas Park, FL 33781 | Phone: (727)999-2076 | Fax: (727)999-2078

REGISTRATION FORM

(Please Print)

REASON FOR YOUR VISIT: ☐ **AUTO** ☐ **WORK RELATED**

Today's Date:	Requested Pharmacy:

PATIENT INFORMATION

Patient's last Name: First: Middle Initial:	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	Marital Status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal Name? ☐ Yes ☐ No	If not, what is your Legal Name?	(Former Name):	D.O.B (Mo/Day/Year):	Age:	Sex: ☐ M ☐ F

Street Address:	Social Security : _ _	☐ Home Phone: ☐ Cell Phone: ( ) E-mail:

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

Occupation:	Employer:	Employer Phone: ( )

Chose clinic because/referred to clinic by (Please check one box)

☐ Ad/Sign ☐ Insurance plan ☐ Hospital ☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages

☐ Our Website ☐ Provider Referral: ☐ Other:

Has any other family members been seen here? ☐ Yes ☐ No

Race Ethnicity (Please check box below)

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific ☐ Black or African American ☐ White

☐ Hispanic ☐ Other

Ethnicity (Please check boxes below)

☐Hispanic or Latin ☐ Not Hispanic or Latin ☐ Refuse to respond

Language

☐ English ☐ Indian(Include Hindi and Tamil) ☐ Spanish ☐ Vietnamese ☐ Sign language ☐ Other

CONTACT IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to Patient:	Home Phone: ( ) Work Phone: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for my balance. I authorized Health Now Family & Urgent Care and/or insurance company to release any information required to process my claims.

Patient/Guardian signature	*Date*

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Consent for Purposes of Treatment, Payment & Healthcare Operations (08/10)

In this document, "I" and "my" refer to the patient, and "Provider" refers to HealthNow.

I consent to the use or disclosure of my protected health information by Provider for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Provider. I understand that analysis, diagnosis or treatment of me by Provider may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Provider is not required to agree to the restrictions that I may request. However, if Provider agrees to a restriction that I request, the restriction is binding on Provider.

I have the right to revoke this consent, in writing, at any time, except to the extent that Provider has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Provider and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Provider. The Notice of Privacy Practices for Provider is also posted in the waiting room. This Notice of Privacy Practices also describes my rights and duties of the Provider with respect to my protected health information.

Provider reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Provider and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative	Printed Name of Patient
Date of Signing	Description of Personal Representative's Authority

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Policies

OFFICE FEES FOR MEDICAL RECORDS: COPIES/FORMS/REPORTS

- ✓ $1.00 per page for copies up to 25 pages, $0.25 per page per copy for 26 pages and more. (FMLA, special forms, Medical Reports, Physical forms, disability forms)
- ✓ Request of medical records/forms a minimum of 5 business days is required.

APPOINTMENT POLICY:

- ✓ Medical records review requires an appointment with the doctor.
- ✓ 24-hour notice is required to reschedule or cancel appointment. NOTE: If the proper notice in not given to cancel or reschedule an appointment, there is a "NO-SHOW fee of $25.00 for a follow-up appointment and $45.00 fee for a physical and/or women wellness appointment.
- ✓ Patients who arrive late for an appointment will be asked to wait to see the doctor until there is sufficient time to complete the visit/appointment or the Patient may be asked to reschedule the appointment.
- ✓ After 5:00 pm and Saturday, patients and walk-ins will be seen and considered as urgent care visits.

TELEPHONE MESSAGE POLICY

- ✓ If necessary telephone messages will have a 48 hour response time.

PRESCRIPTION REFILL POLICY

- ✓ Approved prescription refills require a 3-5 business days notice.

REFERRAL POLICY

- ✓ Referrals require a seven business days notice.
- ✓ Appointments are required for a referral request.

I understand that I am responsible for all charges incurred whether or not paid by the Insurance Company. I agree and understand that I may be also charged a 1.5% interest fee per month on any unpaid balances, and that I am also responsible for any costs incurred in collection of the said balance should collection become necessary. I have read and understand the above information and agree to comply.

Patient Name: _____ **DOB: _____**

Signature:_____ **Date:_____**