LAKE OCONEE URGENT & SPECIALTY CARE CENTER

Registration / Consent / HIPAA

Patient Last Name _____ First Name _____ M ____ ❒Male ❒Female

Date of Birth _____ Social Security _____ Marital Status: ❒S ❒M ❒D ❒W

Home Telephone _____ Alternate Telephone _____ ❒Cell ❒Work ❒Other

Street Address _____

City _____ State ____ Zip Code _____ E-mail _____

Patient Employer _____ Primary Care Physician _____

How did you hear about Lake Oconee Urgent & Specialty Care reserves? ❒**Been Here Before**

❒Drive-By ❒Internet ❒Around Town ❒Newspaper ❒Neighbor ❒Family/Friend ❒ Referral
❒Employer ❒Other ___

Name of Responsible Party or Policy Holder _____ ❒Male ❒Female

Date of Birth _____ Social Security _____ Relationship ❒Parent ❒Spouse

Address (if different from above) _____

Telephone _____ Employer _____

Employer Telephone _____ Employer Address _____

SECONDARY INSURANCE COMPANY

Insurance Company:	Subscriber Number:

EMERGENCY CONTACT INFORMATION

Contact Person:	Phone Number:	Relationship to Patient:

These authorizations, acknowledgements and waivers cover all services rendered to the below patient for today's services and all future dates of service. You may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any events that occurred before you notified us of your decision to revoke

Acknowledgement of Receipt of Notice of Privacy Practices - I have the Notice of Privacy Practices for the patient outlined above. I understand that I may have a written copy to take with me upon my request.

Authorization to Treat & Bill - I give consent for the above named Patient to be treated by Lake Oconee Urgent Care. I authorize the release of any medical and demographic information necessary to process all claims. I authorize payment of medical benefits to Lake Oconee Urgent Care for all services performed and billed by Lake Oconee Urgent Care.
Lake Oconee Urgent Care will submit a claim for service rendered to my insurance carrier and they do so as a courtesy. I

understand that if I do not provide complete and accurate billing / insurance information at the time of service and this prevents Lake Oconee Urgent Care from collecting from my insurance company, I will be responsible for the full charges. I understand I will be held responsible for any balances that remain on the account after the insurance company has paid according to contract.

Cash Pay Patients - I understand that if I choose to be treated as a cash pay patient and I choose not to use or have no other form of insurance as a form of payment, the payment will be due at the time the services are rendered. I understand that a discount will be applied for medical services provided.

Waiver for Non Contracted and Out of Network Insurance Companies - It is my understanding if Lake Oconee Urgent Care is not contracted or my insurance is out of network I may incur a higher out of pocket, meaning that my patient portion may be higher. If my insurance denies my claim for non-contracted services I will be responsible for all balances due.

Waiver for Non Covered Services - It is my understanding that my insurance company may deem all or part of my visit as a non-covered service. I will be responsible for payment for any and all services denied as non-covered.

On Site Prescription Program - Lake Oconee Urgent Care participates in an on-site prescription program and stocks a small quantity of routine prescriptions. I understand that the option is available to me to have my prescription filled / purchased from Lake Oconee Urgent Care. Lake Oconee Urgent Care does not participate in prescription insurance programs; therefore, Lake Oconee Urgent Care will not bill prescriptions to your insurance plan. If you bill your insurance program for prescriptions filled at Lake Oconee Urgent Care, you may or may not be reimbursed. Lake Oconee Urgent Care will not refund any prescriptions for any reason.

Medical Consent - I hereby consent, for myself or dependant, to diagnostic and/or therapeutic medical treatment, procedures and medical imaging as deemed necessary by the provider. I acknowledge that no guarantee can be made regarding the result of any procedure performed or any medical treatment provided.

Medical Release Authorization - I understand that it may become necessary to release my protected health information to another entity for treatment, follow-up, continuation of care, quality assurance, collection purposes and when required by law. Such entities may include but are not limited to primary care and consulting physicians, specialists, hospitalists, insurance companies and collection agencies. Similarly, I understand that Lake Oconee Urgent & Specialty Care may contact me at the numbers provided for purposes related to routine follow-up and the delivery of test results related to my visit. If it is necessary to leave a voicemail message, I understand that it will be limited to notification and the intended purpose of the call.

HIPAA - I acknowledge receipt of the Notice of Privacy Rights with detailed information about how Lake Oconee Urgent & Specialty Care may use and disclose my protected health information. I understand that Lake Oconee Urgent & Specialty Care reserves the right to change the privacy notice and that a copy of the notice will be made available to me.

Safety - I agree, under the provisions of Georgia law, that if any healthcare worker is exposed to my blood or other bodily fluid, I will willingly submit to testing of my blood or other bodily fluid to determine the presence of any communicable diseases. I acknowledge that this may include, but is not limited to, testing for hepatitis, human immunodeficiency virus and syphilis. I understand that such testing is necessary to protect those who will be caring for me while I am a patient at Lake Oconee Urgent & Specialty Care to ensure my own safety as well as the safety of the other patients and healthcare workers.

By signing this form, I am only acknowledging that I have read and understand the policies above. I also understand that not all of the policies may apply to me (or patient if minor).	
Patient Name:	
Parent/Guardian Name (For Minors Only):	Relationship to Patient:
Signature:	Date: