Patient Registration Form

Name (last, first, middle initial)	Home Phone #	Cell Phone #	DOB
Address	City	State	Zip Code
Social Security #	Sex (M/F)	Marital Status	Last Tetanus
Email Address			

Employer Info

Occupation	Employer		Work Phone #
Employer Address	City	State	Zip Code

Primary Insurance Info

Insured's Name			Insured's DOB
Insured's Phone #			Insured's Social Security #
Insured's Address (if different than above)	City	State	Zip Code

Secondary Insurance Info

Insured's Name	Insured's DOB	Insured's Phone #	Insured's Social Security #

Minor/Guarantor's Info

Name of Responsible Party		Relationship to Patient	Responsible Party's DOB
Responsible Party's Social Security #		Driver Lic #	Phone #
Address (if different than above)	City	State	Zip Code

I, the undersigned, being the patient or parent/legal guardian/person having legal custody/or person otherwise having legal authorization to consent, freely give my consent to Laguna Dana Urgent Care (LDUC), and their agents, to examine and treat the patient registered/referenced above. I authorize LDUC to release any medical records that may be requested by a 3rd party payer for the purpose of paying for services rendered, and further authorize the payment from any such medical benefits be made directly to LDUC.

By using insurance for this and other visits, I understand it is my responsibility to know the terms and conditions of my coverage and to provide a copy of the maost current insurance card. I know I have the right to decline treatment recommended by the provider. If i am provided service that is not covered by my insurance, or if my insurance coverage has lapsed, I will be responsible for the charges in full. I understand that if my insurance has not paid after 45 days from teh billing date that I will be billed directly.

By signing below or acceptance of services, I am fully aware that I am financially responsible for all services provided for me by LDUC. If I am using insurance, I understand LDUC will bill my insurance and accept as payment I full the amount the insurance apys, with the exception of co-pays, deductibles, amounts designated as patient responsibility by the insurance, or non-covered services. I also understand the LDUC reserves the right to bill at a later date for any missed charges for the date of service.

Signature of patient/parent or legal guardian | Date

Consent for purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Laguna Dana Urgent Care for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Laguna Dana Urgent Care.

I understand that diagnosis or treatment of my health by Laguna Dana Urgent Care may be conditioned upon my consent as evidenced by my signature on this document.

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 health care operations of the practice. Laguna Dana Urgent Care is not required to agree to the restrictions that I may request. However, if Laguna Dana Urgent Care agrees to a restriction that I request, the restriction is binding on Laguna Dana Urgent Care.

I have the right to revoke this consent, in writing, at any time, except to the extent Laguna Dana Urgent Care 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 understand I have a right to review Laguna Dana Urgent Care's Notice of Privacy Practices prior to signing this document.

Laguna Dana Urgent Care's Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur to my treatment, payment of my bills or in the performance of health care operations of Laguna Dana Urgent Care.

The Notice of Privacy Practices for Laguna Dana Urgent Care is also provided in the waiting room and on Laguna Dana Urgent Care's website at ldurgentcare.com.

The Notice of Privacy Practices also describes my rights and the duties of Laguna Dana Urgent Care with respect to my protected health information.

Laguna Dana Urgent Care 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 accessing the Laguna Dana Urgent Care's website, calling the office 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	Date
______________________________	______________________________
Name of Patient or Personal Representative	Description of Personal Representative's Authority

Have you heard of the Health Insurance Portability and Accountability Act? This act is to protect the patients' privacy. If we need to contact you with test results or instructions from your doctor we need your permission to leave a message if you are unavailable.

☐ You may NOT leave a message

☐ You may only leave a message on the following phone # ____________________

☐ You may leave a message on the answering machine and or with any family member.

☐ You may fax information to me at this phone # ____________________

______________________________ ______________________________

Your Signature Date

____

Printed Name