Patient registration forms

Rapid MD LLC

PATIENTS NAME: _____

ADDRESS: _____

TOWN: _____ **STATE**_____**ZIP CODE**_____

DATE OF BIRTH: _____ **SEX: MALE ( ) FEMALE ( )**

SOCIAL SECURITY NUMBER: _____

TELEPHONE NUMBERS ( ) _____ **H ( ) W ( ) C ( )**

TELEPHONE NUMBERS ( ) _____**H ( ) W ( ) C ( )**

TELEPHONE NUMBERS ( ) _____**H ( ) W ( ) C ( )**

EMAIL ADDRESS: _____

EMPLOYERS NAME: _____

EMPLOYERS ADDRESS: _____

EMERGENCY CONTACT: _____

REASON FOR TODAY'S VISIT; _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____

PRIMARY INSURED'S NAME: _____

MEMBER ID: _____**POLICY#:**_____**GROUP #:**_____

RELATIONSHIP TO THE INSURED: ( ) SPOUSE ( ) CHILD ( ) OTHER_____

SECONDARY INSURANCE NAME: _____

MEMBER ID: _____**POLICY#:**_____**GROUP#:**_____

RELATIONSHIP TO THE INSURED: ( ) SPOUSE ( ) CHILD ( ) OTHER_____

IS THIS AN AUTO ACCIDENT ( ) YES ( ) NO OR WORK RELATED INJURY? ( ) YES OR ( ) NO

INSURANCE CARRIER; _____ **POLICY#**_____

POLICY HOLDERS NAME; _____

CLAIM NUMBER: _____

DATE OF ACCIDENT: _____

AUTHORIZATION TO TREAT

I HEREBY AUTHORIZE RAPID MD LLC, IMMEDIATE MEDICAL CARE, AND ITS STAFF TO PROVIDE ME WITH MEDICAL TREATMENT. I AGREE TO INFORM RAPID MD LLC, IF I HAVE ANY CONCERNS ABOUT MY MEDICAL TREATMENT AT THE TIME SERVICES ARE RENDERED. THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE RAPID MD LLC, OR INSURANCE COMPANY TO RELEASE ANY INFORMATION IN PROCESSING ANY CLAIMS. I AUTHORIZE ANY "IN NETWORK" INSURANCE BENEFITS TO BE PAID DIRECTLY TO RAPID MD LLC, IMMEDIATE MEDICAL CARE. I AGREE TO PAY FOR ALL URGENT CARE SERVICES IN FULL AT THE TIME OF SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL URGENT CARE CHARGES WHETHER OR NOT PAID FOR BY MY INSURANCE. I UNDERSTAND THAT IF SYMPTOMS PERSIST OR GET WORSE I SHOULD SEEK ADDITIONAL MEDICAL CARE.

PATIENT/LEGAL GUARDIAN SIGNATURE X_____ DATE____/____/____

HOW DID YOU HEAR ABOUT RAPID MD?

( ) FAMILY /FRIEND ( ) REFERRED BY SOMEONE_____

( ) YELLOW PAGES ( ) INTERNET ( ) WALK IN

I HAVE RECEIVED THE HIPPA NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

PAITENT/LEGAL GUARDIAN SIGNATURE X_____DATE____/____/____

PATIENT HIPAA AWARENESS

AS RESULTS OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), ENFORCED BY THE US DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE OF CIVIL RIGHTS, WE ARE NOT PERMITTED TO RELEASE PATIENT INFORMATION EXCEPT AS STATED IN THE NOTICE OF PRIVACY PRACTICE OR IN ACCORDANCE WITH YOUR WISHES AS STATED BELOW.

THIS WAIVER AUTHORIZES RAPID MD LLC TO SEND/GIVE MEDICAL INFORMATION AS NOTED:

PATIENT NAME (FIRST) _____ (LAST) _____ (PLEASE PRINT)

LEAVE A VOICE MAIL RECORDING INCLUDING MY PERSONAL HEALTH INFORMATION ON MY HOME/CELL PHONE: **_____ YES _____ NO**

LEAVE A VOICE MAIL RECORDING INCLUDING MY PERSONAL HEALTH INFORMATION ONMY BUSINESS PHONE: **_____YES_____NO**

PERMIT THE INDIVIDUAL STATED BELOW (PERSONAL REPRESENTATIVE)
_____YES_____NO
TO RECEIVE PRESCRIPTIONS AND/OR TEST RESULTS:

SPEAK TO A FAMILY MEMBER OF MY CHOOSING (PERSONAL
_____YES_____NO
REPRESENTATIVE), REGARDING MY PERSONAL HEALTH INFORMATION

NAME OF PERSONAL REPRESENTATIVE: _____

ON THIS DATE, _____/_____/_____, I RECEIVED AND REVIEWED RAPID MD LLC'S NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES HOW MY MECIAL INFORMATION MAY BE USED AND DISCLOSED AND EXPALINS HOW I CAN GET ACCESS TO THIS INFORMATION.

THE AUTHORIZATIONS MADE ABOVE WILL REMAIN EFFECTIVE UNTIL SUCH TIME AS I NOTIFY RAPID MD LLC IN WRITING, BY CERETIFIED MAIL OF REQUESTED CHANGES.

_____ _____

SIGNATURE OF LEGAL GUARDIAN **PATIENT'S NAME**

_____ _____

PRINT NAME OF PATIENT OR LEGAL GUARDIAN **Date**