URGI-Kids
I.PARK NORWALK

Arrival Time: Registration Form

1. PATIENT INFORMATION

Patient Name_____D/O/B_____Sex ☐ M ☐ F

Home Phone # (____)_____ Cell Phone # (____)_____

Mailing Address_____Apt #_____City_____State_____Zip_____

Primary Care Physician (PCP)_____ PCP Phone Number_____

PCP Fax Number_____

2. ACCOMPANYING ADULT INFORMATION

Accompanying Adult Name_____Relationship to patient_____

Address (if different from patient)_____City_____State_____Zip_____

Home Phone # (if different from patient): (____)_____ Work phone #_____

3. FINANCIAL INFORMATION

Insurance Policyholder's Name_____Relationship to Patient_____

Email Address_____Social Security Number_____D.O.B._____

Insurance Co Name _____Insurance Co Phone_____

Insurance Co Address_____City_____State_____Zip_____

Policyholder_____ID #_____Group #_____Plan #_____Employer Name_____

4. REFERRAL INFORMATION

HOW DID YOU LEARN ABOUT URGI CARE?

☐ Direct Mail ☐TV ☐Saw your sign ☐Previous Visit ☐Yellow Pages ☐Newspaper

☐Health Fair ☐Magazine ☐ Radio ☐Insurance Co. ☐Family/ Friend ☐Employee

☐Primary Care Doctor _____ ☐Specialist_____

5. CONSENT & RELEASE

CONSENT TO TREATMENT: I understand that medical treatment of urgent nature is necessary for the patient and that such medical care, treatment and procedures will be performed by physicians and non-physicians employees of Urgi Kids during normal operating hours. I understand that medical treatment only is being provided , and that no responsibility will be take for long-term patient care or care after normal hours of operation. I hereby grant my authorization and consent for such treatment and procedures, and certify that no guarantee of assurance had been made as to the results which may be obtained.

AUTHORIZATION FOR MEDICAL RELEASE: I authorize Urgi Kids to release any medical information in connection with these services for health insurance purposes or to any physician involved in the ongoing treatment of this patient.

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY: I hereby assign all medical and/or surgical benefits to which I am entitled, including government sponsored programs, private insurance and other health plans to Urgi Kids. This assignment shall remain in effect until revoked by me in writing. I hereby authorize said Assignee to release all information necessary to secure the payment which is to be issued directly to Urgi Kids for their services as described herein. I understand that I am financially responsible for all charges whether or not paid by my insurance. I promise to pay Urgi Kids all charges , copayments, deductibles and coinsurance amounts for the services rendered to or on behalf of the patient at the time of service. I further agree to pay all collection costs and attorney fees should the account become delinquent and be referred to a collection agency. I n addiction, I may be charged 18% annual interest on any unpaid balance.

OUT OF NETWORK INSURANCE PLANS ONLY: I understand that URGI Kids will file my insurance claims for services rendered to the patient as an out-of network or non- contracted provider. I understand that I will be financially responsible for all applicable non-paid charges.

ACCOMPANYING ADULT SIGNATURE_____ DATED _____

MEMBERS OF OXFORD H.M.O. AND AETNA H.M.O. ARE FINANCIALLY RESPOPNSIBLE FOR THE COST OF THE VISIT SINCE THESE H.M.O. PRODUCTS ALLOW YOU ONLY TO SEE YOUR PRIMARY CARE PHYSICIAN.

PLEASE NOTE THAT WE DO NOT ACCEPT ANY STATE OR GOVERNMENT PLANS SUCH AS ANY MEDICAID PRODUCT OR MILITARY PRODUCT.

A PHOTOCOPY OF ALL INSURANCE CARDS AND DRIVER'S LISCENSE IS REQUIRED

OR OFFICE USE ONLY:

EMPLOYEE WHO ACCEPTED FORM INITIAL:_____

UNIT COORDINATOR INITIALS: _____UC CHECK-IN TIME:_____