Last Name: ______________________ First Name: ______________________

Date of Birth: ______________________ Date of Visit: ______________________

Age: ______________________ Sex: ☐ MALE ☐ FEMALE

Race/ Ethnicity: ______________ Preferred Language, if other than English: ______________________

Address: ______________ Apt #: ______ City: __________ State: ______ Zip: ______

Home Phone: ______________________ Cell Phone: ______________________

Work Phone: ______________________ Email: ______________________

Social Security Number: ______________________ Marital Status: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

Reason for your visit today: ____

Is this an injury resulting from a work or motor vehicle accident? ☐ YES ☐ NO

Emergency Contact Name: ______________________ Relationship: ______________________

Emergency Contact Phone: ______________________

Primary Care Physician (PCP) Name : ____
Please note we routinely send correspondence to PCP for continuity of care.

PCP Office Location: ______________________ PCP Office Phone: ______________________

Preferred Pharmacy: ______________________

Location (Cross streets): ______________________ Pharmacy Phone: ______________________

In order to process your claim, please complete below if the patient is NOT the POLICY HOLDER on your insurance.

Policy Holder's Name: ______________________ Relationship: ______________________

Insured's SSN: ______________________ Insured's Date of Birth: ______________________

Address: ______________ Apt #: ______ City: __________ State: ______ Zip: ______

Main Phone: ______________________

NOTICE OF PRIVACY PRACTICES

See office file, copies of this form will be made available upon request.

I hereby acknowledge that I have received and read a copy of the organization's Notice of Privacy Practices.

PATHOGEN EXPOSURE POLICY

I understand that in the event of any healthcare providers exposure to my blood and/or body fluids, I shall be deemed to have consented to laboratory testing for HIV, Hepatitis B, and Hepatitis C with release of results to the person exposed.

GUARANTEE OF PAYMENT AND ASSIGNMENT OF INSURANCE BENEFITS

1. **The undersigned promises to pay Fast Track Urgent Care Center for all charges incurred and to be incurred for services rendered and/or goods furnished.**
2. **Payment in full is expected at time of service; including Copays, Co-Insurance, and Deductibles as assigned by your insurance.**
3. **Any additional services rendered, but not billed on the day of service, or any additional responsibility for charges your insurance may assign to you, will be billed directly to you.**
4. Fast Track Urgent Care requires all patients to establish an Account on File wherein our processing system will store a payment method (credit/debit card or bank account information), using an encryption and tokenization process to electronically debit your account a one-time payment up to the lessor of our balance or $150.00. Any remaining balance will be billed directly to you.
5. Fast Track Urgent Care Center makes every effort to collect accurate patient responsibility at time of service based on the information provided by your insurance carrier. Fast Track Urgent Care Center expects prompt payment in full for services rendered. If you think your bill is incorrect, please call or write us at the address shown on your bill as soon as possible. If it is found that an incorrect amount was collected and you are due a credit, Fast Track Urgent Care will credit your patient account. If the amount of your credit is greater than $10.00 Fast Track Urgent Care will issue a refund check.
6. A discounted fee schedule will be applied to all self-pay patients who pay at the time of service. Additional services rendered but not charged will be billed to the patient at the discounted rate. Payment not received in a timely manner will result in loss of discount rate for the outstanding balance, additional collection fees and account forwarded to a collection agency. The discounted rate does not apply to patients with insurance. Once services are paid at the discounted rate they are not eligible for claim submission at a later date by Fast Track Urgent Care Center.
7. Payments made by check may be processed as an electronic debit to your account. Paper checks or electronic debits that fail to clear may be resubmitted electronically and are each subject to a service charge of $25.00.
8. If an account is turned over to an outside party for collection, the undersigned agrees to pay all costs of collection, including a service charge of 30% of all sums due, and attorney's fees.
9. The undersigned hereby assigns any and all insurance benefits to Fast Track Urgent Care Center, and authorizes Fast Track Urgent Care Center to act as agent in helping obtain payment from the indicated insurance companies. The undersigned authorizes use of this form on all insurance claim submissions. The undersigned understands that Fast Track Urgent Care Center will file the patients insurance claim(s) as a courtesy to the patient and authorizes Fast Track Urgent Care Center to release any and all information necessary to perfect said insurance claim(s) and/or to collect any balance due to Fast Track Urgent Care Center; however, it is understood and agreed that the patient and/or the undersigned is responsible for perfecting and following up on any insurance claims.
10. "Any person who, knowingly and with intent to injury, defraud, or deceive an employer or employee, insurance company, or self- insured program, files a statement of claim containing and false or misleading information commits insurance fraud, punishable as provided in s. 817.234" under Florida statutes.

Account on file: American Express Discover MasterCard Visa Checking/Savings (info captured at check-out)

I hereby acknowledge that I have received and read a copy of the organization's Notice of Privacy Practices, Pathogen Exposure Policy and the Guarantee of Payment Policy, and the information that I have provided is accurate and correct.

____ ____________________

Patient Signature or Signature of Authorized Representative of Patient **Date**