SOUTH TAMPA IMMEDIATE CARE **_PATIENT REGISTRATION_**

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*****REASON FOR TODAY'S VISIT ____

IF ACCIDENT: ________________________DATE ________________________AUTO _________________________WORK _______________________OTHER

EXPLAIN____

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PATIENT NAME: (LAST_____________________________________ (FIRST) ______________________________ (M) _____ HOME PHONE (_______) ________________

ADDRESS: ____ APT____________CELL PHONE (_______) __________________

CITY____STATE ____________ZIP CODE ______________E-MAIL _________________________________

MAILING ADDRESS (IF DIFFERENT FROM ABOVE) ____

CITY ____STATE____________ZIP CODE_________________ FIRST VISIT TO CLINIC? ______ YES _______ NO

DATE OF BIRTH________/________/____________ AGE_______ **GENDER: MALE FEMALE SOCIAL SECURITY #** ___________-_________-________________

RACE ___________________ETHNICITY (HISPANIC OR NOT HISPANIC)_____________________LANGUAGE______________________ DOMINATE HAND ______ Rt _______ Lt

EMPLOYED: ____ FULL TIME ____PART TIME ____ FULL TIME STUDENT _____ PART TIME STUDENT ______**SINGLE** ____**MARRIED** _____**WIDOW(ER)** _____ **OTHER**

EMPLOYER____OCCUPATION___________________________WORK PHONE (______) ____________________

PRIMARY CARE PHYSICIAN ____ TELEPHONE____

RESPONSIBLE PARTY / RELATIONSHIP FATHER MOTHER LEGAL GUARDIAN OTHER ____

NAME____DATE OF BIRTH_______________________ SS#_____________________________

PHONE____ EMPLOYER NAME ____

ADDRESS (IF DIFFERENT FROM ABOVE) ____

PRIMARY INSURANCE ____**SUBSRIBER SS# / /MEMBER ID#**____

SUBSCRIBER (IF DIFFERENT FROM PATIENT) ____ DATE OF BIRTH_____________________RELATION _________________

SUBSCRIBER ADDRESS ____ CITY_____________________________STATE______________ZIP CODE__________

SECONDARY INSURANCE____ SUBSCRIBER ____

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<u>HIPPA</u> **AUTHORIZATION AND AGREEMENT FOR MEDICAL TREATMENT**

CONSENT OF TREATMENT: I hereby grant my authorization and consent to such treatment and procedures, and certify that no guarantee or assurance has been made as to the results obtained.

COMPLICATIONS: I understand that it is my responsibility to return to the South Tampa Immediate Care Clinic or report any change in my condition to the Clinic's doctor.

AGGREEMENT TO PAY SERVICES: For and in consideration of the care and treatment provided to the patient, I promise to pay South Tampa Immediate Care Clinic all charges for services rendered to or on behalf or the patient. Authorization from my insurance company does not always guarantee payment. The undersigned and/or patient shall remain responsible for all charges. Payment to South Tampa Immediate Care Clinic is due upon receipt of statement.

PRIVACY NOTICE: I acknowledge that I have received South Tampa Immediate Care Clinic Privacy Notice., **PLEASE INITIAL** ______________

I AUTHORIZE SOUTH TAMPA IMMEDIATE CARE TO SUBMIT A CLAIM TO THE INSURANCE COMPANY ON MY BEHALF. **PLEASE INITIAL** ______________

I AUTHORIZE SOUTH TAMPA IMMEDIATE CARE TO DOWNLOAD MY MEDICATION HISTORY FROM A PHARMACY CLEARINGHOUSE. **PLEASE INITIAL** ______________

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE ABOVE AND IS THE PATIENT, GUARANTOR OR THE PATIENT'S REPRESENTATIVE DULY AUTHORIZED TO EXECUTE THIS
AGREEMENT AND ACCEPT ITS TERMS.

DATE ____ x____

SIGNATURE OF PATIENT / REPRESENTATIVE

____ ____

PRINT REPRESENTATIVE NAME REPRESENTATIVE'S RELATIONSHIP TO PATIENT

Please list the family members or other person, if any, who we may inform about your general medical condition and your diagnosis (including treatment, payment and health condition)

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IN CASE OF EMERGENCY: Please list the family members or significant others, if any whom we may inform about your medical condition

NAME ____ PHONE ____
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