Bayside URGENT CARE CENTER

Date: _____

New Patient Registration Form (please print clearly)

PATIENT INFORMATION

PATIENT NAME: FIRST MIDDLE LAST

RESPONSIBLE FOR PAYMENT? ☐ YES ☐ NO

PATIENT ADDRESS: NUMBER & STREET APT# | CITY | STATE | ZIP | COUNTRY (if not US)

HOME PHONE # | MOBILE PHONE # | REASON FOR VISIT:

DATE OF BIRTH: | GENDER: ☐ MALE ☐ FEMALE | MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOW ☐ OTHER

OPTIONAL DEMOGRAPHIC INFO

RACE: ☐ AMERICAN INDIAN or ALASKAN NATIVE ☐ ASIAN ☐ BLACK or AFRICAN AMERICAN ☐ WHITE

PREFERED LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ OTHER_____

ETHNICITY: ☐ HISPANIC or LATINO ☐ NOT HISPANIC or LATINO

PHARMACY USED (NAME, ADDRESS, TELEPHONE NUMBER)

IF YOU ARE A NEW PATIENT, HOW DID YOU HEAR ABOUT US: (CHOOSE ONE) ☐ FAMILY/FRIEND/PATIENT

☐ PHARMACY (please indicate where) _____ ☐ PHYSICIAN REFERRAL (please indicate who)_____

☐ SAW OFFICE SIGN/WALK-IN ☐ MAILING ☐ COMMUNITY EVENT ☐ ER/HOSPITAL

☐ ADVERTISEMENT ☐ INSURANCE COMPANY ☐ INTERNET/GOOGLE ☐ INTERNET (FACEBOOK)

☐ OTHER_____

IF PATIENT IS A MINOR/DEPENDENT (under the age of 18), PROVIDE PARENT/GUARDIAN INFORMATION

PARENT/GUARDIAN NAME: FIRST LAST: | RESPONSIBLE FOR PAYMENT? ☐ YES ☐ NO

ADDRESS: NUMBER & STREET APT # | CITY | STATE | ZIP | COUNTRY

HOME PHONE # | MOBILE PHONE # | YOUR DATE OF BIRTH

INSURANCE INFORMATION

PRIMARY INSURANCE | SUBSCRIBER'S EMPLOYER | EFFECTIVE DATE

POLICY # | GROUP # | INSURANCE COMPANY BILLING ADDRESS

POLICY HOLDER'S NAME | RELATIOINSHIP TO PATIENT | SOCIAL SECURITY NUMBER | DOB

SECONDARY INSURANCE | SUBSCRIBER'S EMPLOYER | EFFECTIVE DATE

POLICY # | GROUP # | INSURANCE COMPANY BILLING ADDRESS

POLICY HOLDER'S NAME | RELATIOINSHIP TO PATIENT | SOCIAL SECURITY NUMBER | DOB

PERSON TO NOTIFY IN CASE OF AN EMERGENCY

NAME: FIRST LAST | RELATIONSHIP TO PATIENT

HOME PHONE # | MOBILE HONE # | WORK/OTHER PHONE #

PRIMARY CARE PHYSICIAN

PHYSICIAN NAME | PHONE #

ADDRESS: | CITY | STATE | ZIP

Important information regarding your visit and future visits with our facility

Financial Responsibility and Waiver of "Usual, Customary and Reasonable" Clause:

In order to control your cost of billing, we request that our charge for office visits be paid at the conclusion of each visit and that you will assume and guarantee prompt payment of all expenses due. You understand that the fees charged by Bayside Urgent Care Center may exceed "usual, customary and reasonable", due to specialized services given by staff, and you have agreed to pay the fees in full, even if the final amount is greater than what you are reimbursed for from your insurance company or third party payor.

Please **initial below**, authorizing Bayside Urgent Care Center to bill your insurance company and/or Medicare you have provided for our services to you.

☐ Commercial Insurance/Third party payer ☐ Medicare ☐ Medigap/Medicare Supplement

"Non - Covered" Services:

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance for services not paid or not covered by your insurance.

Protecting your privacy:

Bayside Urgent Care Center will **NOT** share your medical information to anyone other than you without your written permission. List names of those you allow us to share your health information with:

Name:	**Relationship:**
_____	_____
_____	_____
_____	_____

May we leave confidential messages on: Voicemail/Answering Machine? □ Yes □No

E-mail address we may send confidential records to upon your request:

_____

Permission for Treatment:

Permission is granted for physicians and employees of Bayside Urgent Care Center to render the patient named below such medical and surgical treatment as deemed necessary.

Notice of Privacy Practices:

Please acknowledge that you have been provided with Bayside Urgent Care Center's HIPAA Notice of Privacy Practices and have read, understood, and agreed to the notice along with all the provisions regarding responsibility of payment and permission of treatment. You understand that I can obtain a copy of the most current HIPAA notice upon request.

Treatment Evaluation Form:
To ensure that we provide the best service, we have contracted with a firm to send our patients a patient service evaluation form. Please initial if you agree that we may send you this form. _____

If you agree to receive the patient service evaluation form, please indicate if this should be sent to a different street/post office box, or email address, please enter it here: _____
_____

I have read all of the above and understand/agree to its provisions regarding myself or the patient I assume responsibility and guardianship of.

Patient's Name (print): _____

Patient or Legal Guardian's Signature: _____ Date: _____

If Legal Guardian, Relationship to Patient: _____

Bayside Urgent Care Center
727-441-5044
727-441-5008 (fax)

Financial Policy

1001 S. Ft. Harrison Ave
Suite 101
Clearwater, FL 33756

This is an agreement between Bayside Urgent Care Center and the Patient/Guardian/Guarantor named on this form.

In this agreement the words "you," "your," and "yours" mean the Patient/Guardian/Guarantor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Bayside Urgent Care Center.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payment options if you have no insurance:

1. You may pay by cash, check, or credit card on the day that treatment is rendered.
2. You may pay in installments with 50% at time of service and the remaining balance via credit/debit card kept on file.

Payment options if you have insurance:

1. You may pay towards your deductible and any out-of-pocket portions at the time services by cash, check, or credit card.
2. You choose to pay all of your treatment by cash, check, or credit card. We will request your insurance carrier send their payment directly to us.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Out of State HMO Insurance Plan: It is the patient's responsibility to get authorization for out of state service. Failure to do so may result in the patient being responsible for the entire visit balance in full.

The Financial Policy continues on the back side of this page.

Patient's name: _____

Responsible party
(If not the patient): _____

Signature: _____ Date: _____

Co-Signature: _____ Date: _____

Bayside Urgent Care Center
727-441-5044
727-441-5008 (fax)

Financial Policy

1001 S. Ft. Harrison Ave
Suite 101
Clearwater, FL 33756

Off site services: You are responsible for payment in full for services that are performed outside of Bayside Urgent Care Center. These services include but are not limited to laboratory blood work that are tested at a laboratory location &/or radiology services. These fees are subject to the offsite facility which is not affiliated with fees of Bayside Urgent Care Center. You are responsible for rendering payment to the offsite facility.

Credit History: We have the option to report your account status to any credit reporting agency such as a credit bureau.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Returned checks: There is a fee (currently $25) for any checks returned by the bank.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. These necessary steps may include referring your account to a collection agency. We may also refer collection of the balance to a lawyer. In case of suit, you agree the venue shall be in Pinellas County, Florida.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if you're past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent(s) responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Workers Compensation: We require written approval/authorization by your employer and/or worker(s) compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Assignment of Benefits: (AOB) We require that you allow us to file claims and collect insurance payments without your involvement.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Initial _____

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Payment options if you have no insurance:

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Payment options if you have insurance:

1. You may pay towards your deductible and any out-of-pocket portions at the time services by cash, check, or credit card.
2. You choose to pay all of your treatment by cash, check, or credit card. We will request your insurance carrier send their payment directly to us.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

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Patient's name: _____

Responsible party
(If not the patient): _____

Signature: _____ Date: _____

Co-Signature: _____ Date: _____

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Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if you're past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

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Assignment of Benefits: (AOB) We require that you allow us to file claims and collect insurance payments without your involvement.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Initial _____

Visit Follow-up Communication

TEXT MESSAGE AND INFORMED CONSENT: In order to enhance patients' care and experience Bayside Urgent Care Center may contact you after your visit in order to request feedback on your experience by phone call, SMS text message, e-mail, voicemail, or mobile application, some of which may be via automated means. By signing below you understand and agree to be contacted in this manner with communications related to this visit, and any future visits.

In the future, you may opt-out of receiving text messages by notifying us in writing (including responding via text message). Standard telephone minute and text charges may apply if we contact you.

MOBILE SAFETY TIPS: While we work hard to protect your information, remember that electronic communication is never 100% secure. It's very unlikely, but information you send via text, email or mobile application, or that you leave on your mobile device, could be exposed to people other than your doctor. Here are a few safety tips to follow:

(1) Use a password on your mobile device to prevent strangers from seeing what is on your phone.

(2) Limit the amount of sensitive health information you send. You can always call your provider to discuss something private or sensitive.

(3) If you are worried about those close to you seeing your messages, you can delete them from your email or messaging app. This won't erase them completely, but will make it hard for others to see them.

Patient Signature: _____

Date: _____

Name:_____ Date of Birth:_____Date:_____

Please list all medications you take: None:_____

Medication	What condition is it for?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any current and past medical conditions such as diabetes, high blood pressure, COPD, etc.
None:_____

_____ _____

_____ _____

_____ _____

Please list any allergies you know of: None:_____

_____

Please list any surgeries you have had and the year it was done: None:_____

_____ _____

_____ _____

_____ _____

Patient Signature:_____

Bayside URGENT CARE CENTER

1001 S. Ft. Harrison Ave., Ste 101
Clearwater, FL 33756-3905

Phone (727) 441-5044
Fax (727) 441-5008

HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information.
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you to pay your health care bills, to support the operation of the physician's practice , and any other use required by law.

2. Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

3. Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

4. Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglects: Food and Drug Administration requirement: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Sections 164.500.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information as necessary to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you information about products or services that we believe may be beneficial to you.

Bayside URGENT CARE CENTER

1001 S. Ft. Harrison Ave., Ste 101
Clearwater, FL 33756-3905

Phone (727) 441-5044
Fax (727) 441-5008

You may contact our Privacy Contact to request that these materials not be sent to you.
Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object Unless Required By Law,

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken anaction in reliance on the use or disclosure indicated in the authorization.

You're Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes;information **compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information** that is subject to law that prohibits access to protected health information.

You have the right to request a restriction on your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any partof your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use anddisclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. Wewill accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation for you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy **Practices.**

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at this time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

Complaints

You may complain to us or to the Office of Civil Rights if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. You may obtain the address of the OCR Regional Manager, Denver, CO, from our privacy officer.

Bayside Urgent Care Center: 727-441-5044.This notice was published and becomes effective on/or before April 1. 2012.

1001 S. Ft. Harrison Ave., Ste 101
Clearwater, FL 33756-3905

Phone (727) 441-5044
Fax (727) 441-5008

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____.Signature:_____Date:_____