IMMEDIATE CARE OK

PATIENT REGISTRATION

Patient Name _____ Best #: (_____) _____
Mailing Address _____ City/State/Zip _____
Date of Birth _____ Sex: M F Marital Status: _____ Social Security #: _____
Secondary #: (_____) _____ Email Address: _____
Employer Name _____ Work #: (_____) _____
Employer Address _____ City/State/Zip _____
Primary Physician: _____Address: _____Phone #: (____) _____

PARENT/GUARDIAN INFORMATION IF PATIENT IS A MINOR

PLEASE PROVIDE COPY OF PHOTO IDENTIFICATION
Guarantor Name _____ Telephone #: (_____) _____
Mailing Address _____ City/State/Zip _____
Social Security #: _____ Date of Birth _____ Cell #: (_____) _____
Employer Name _____ Work #: (_____) _____
Employer Address _____ City/State/Zip _____

PRIMARY INSURANCE

PLEASE PROVIDE COPY OF INSURANCE CARD – COPY FRONT AND BACK OF ALL INSURANCE CARDS.
Name of Policy Holder_____ Relationship to Patient _____
Holder's Address _____ City/State/Zip _____
Telephone # (____) _____Date of Birth _____Social Security # _____
Holder's Employer _____Work # (_____) _____
Employer Address _____ City/State/Zip _____

SECONDARY INSURANCE

Name of Policy Holder: _____Relationship to Patient: _____
Holder's Address: _____ City/State/Zip _____
Telephone #: (____) _____Date of Birth _____Social Security #: _____
Holder's Employer _____ Work #: (_____) _____
Employer Address _____ City/State/Zip_____

OPTIONAL (Please Circle One)

Race (Optional) American Indian African American Asian Caucasian Hispanic Other

Authorization/Consent to Treat

GENERAL CONSENT TO TREATMENT- My signature below affirms that I agree/consent to the performance of diagnostic and therapeutic procedures deemed necessary by the patient's provider(s). I acknowledge that there are no guarantees, expressed and/or implied, as to the results of any and all medical procedure(s) or treatment(s).

RELEASE OF INFORMATION- I authorize the provider(s) providing services on behalf of the patient to release all billing information (including information of substance abuse and HIV status, if applicable) to providers or institutions providing follow-up care, the Social Security Administration, Medicare, Medicaid (or their intermediaries), insurance companies, health maintenance organizations, employers, law enforcement, or person(s) acting on behalf of a preferred provider arrangement or third party names on this patient information form (or any of their agents or representatives) when said information is requested for payment, worker's compensation, utilization review, or coverage determination purposes. I understand this authorization remains in effect unless revoked by me in writing and delivered to this TEAM Clinics office.

CONTACTING PATIENTS- You expressly consent and agree that, in order to discuss or service your accounts(s) (the "Accounts") or to collect amounts you may owe, TEAM Clinics, and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively, "We") may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contact you by sending text messages, emails, using any e-mail address you provide to us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

ASSIGNMENT OF INSURANCE- I authorize any insurance benefits to pay directly to the providers providing services to the patient, all benefits due and payable as a result of services rendered.

ACKNOWLEDGMENT OF RESPONSIBILITY TO PAY FOR SERVICES- I understand that the provider(s) will, as a courtesy, file claims with all insurance carriers. However, I acknowledge and agree, except as provided by law, and in consideration of the service provided, that I will pay any charges which for any reason are not paid by any third party payer unless there is a specific written agreement between the provider and the patient and payer.

MEDICARE PATIENTS- Medicare will pay only for service(s) it determines to be "reasonable and necessary." I understand and agree to be personally and fully responsible for payment of charges for provider recommended service(s) and/or procedure(s) of which Medicare may deny payment.

PATIENT RIGHTS- The Patient, or his or her representative, hereby acknowledges acceptance of information, including a copy of the Code of Mutual Trust, which is general information concerning your rights/responsibilities.

Do you have an Advanced Directive? Yes No

Would you like additional information regarding Advanced Directives? Yes No

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES- A complete description of how my medical information will be used and disclosed by TEAM Clinics is in the "Notice of Privacy Practices," which I read before signing this agreement. I hereby acknowledge that a copy of same is available to me upon request and also posted in the clinical site. I have received a copy of the TEAM Clinics "Notice of Privacy Practices" and agree and accept. Any reason for refusal is hereby explained:_____

TEAM Clinics School Clinic Terms of Financial Responsibility – Please read and initial the following:

____ I understand that I will be required to present my insurance card and personal identification EACH time I come to TEAM Clinics. Please understand that TEAM Clinics acknowledges this inconvenience to you; however, due to the rise in identity theft and changes in insurance coverage and providers, we must have your current information.

____ I understand that I am responsible for any/all monies/charges due as a result of service(s) rendered by TEAM Clinics and its providers. Amounts estimated or known to be payable by me are due and payable at the time of check-in or out. Please understand that billing you is based on insurance claim processing; we cannot just send you a bill.

____ I understand that my insurance coverage for TEAM Clinics may differ from my provider's office or an emergency room. I understand and agree that I am responsible for any charges or amounts due and not paid by my insurance.

____ I understand that TEAM Clinics files my insurance claim as a courtesy to me as a patient. Filing may be either electronic or by mail, based on the requirements of the insurance carrier.

____ I understand that TEAM Clinics will ask for and is required to have certain personal information such as name, address, social security number, date of birth and other for the patient, policy holder and/or guarantor. This information will be used to file insurance claims and secure payment(s) for services.

____I understand that I or my employer may have "opted out" of certain TEAM Clinics benefit/payment arrangements. I understand and agree that I am responsible for any balance or monies due on my account.

____I understand that certain dental procedures are not covered by my insurance. I understand and agree that I am responsible for non-covered charges relating to those procedures or services.

____I understand that if my insurance coverage requires a referral or authorization, I am fully responsible for that process. In the event that this process is not completed and the claim denied, I understand and agree that I am responsible for any and all charges/balances that are outstanding and due.

CERTIFICATION- By my signature below, I certify that I have read each of the above statements and acknowledge that they are true and correct. I acknowledge that I have requested an explanation of any item I have concerns about, and that process has been completed to my satisfaction. I also certify that I am the patient or am duly authorized by the patient to sign this agreement and accept its terms.

_____	_____	_____
SIGNATURE OF PATIENT/GUARANTOR OR AUTHORIZED PERSON	RELATIONSHIP TO PATIENT	DATE SIGNED