PHONE: (662) 570-4507
FAX: (662) 570-4510

WEEKENDS Plus Urgent Care

3189 HWY 45 N
HOLLY HILLS PLAZA
SUITE H
COLUMBUS, MS 39705

Patient Registration Form

Patient Information

Name: _____ **Male Female** **DOB::** _____ **SS #:** _____

Address: _____ **Apt #:** _____

City, State, Zip: _____

Phone: _____ **Email:** _____

If the patient is a minor, what is your relationship to the patient? _____

Primary Care Physician: _____ **Phone:** _____

Race

American Indian or Alaska Native | Black or African American | White | Other
Asian | Native Hawaiian/Other Pacific Islander | Decline to Specify

Emergency Contact(s)

These persons will be contacted in emergencies and allowed to receive information about your medical treatment.

Name: _____ Relationship: _____ Mobile Phone _____

Name: _____ Relationship: _____ Mobile Phone _____

Financial Responsibility

Name: _____ Relationship: _____

DOB: _____ Phone: _____

Insurance Information

Primary Insurance: _____ Secondary Insurance: _ _____

Subscriber #: _____ Subscriber #: _____

Subscriber Name: _____ _____ Subscriber Name: _____

DOB: _____Relationship: _____ DOB: _____Relationship: _____

Consent for Treatment/Acknowledgment of Privacy Practices/Acknowledgment of Financial Responsibilities

I, the undersigned, consent to the care and treatment by the attending Physician, his/her associates or assistants and acknowledge that no guarantees have been made as to the effect of such treatment.

I have reviewed the Notice of Privacy Practices as provided at registration and understand that I may request a copy of the policy at any time.

I, acknowledge full financial responsibility to any services received and I understand that the payment of charges incurred in this office is due at the time of service. I also understand that the charges not covered by insurance remain my responsibility. In the event that my account is turned over to a collection agency, I agree to pay all late fees, costs of collection fees and/or Attorney s fees and all court costs, if any. I understand that any services not provided directly by **Weekends Plus Urgent Care** *(Lab results, diagnostic services) are a separate charge and those charges will be billed separately by the provider of such services.*

Consent to release/receive confidential information.

I authorize the health care professional at the above address to: (1) Receive my medical history information from my primary care physician (2) Receive my prescription records from my pharmacies (3) Release my treatment information/records to pertinent healthcare professionals, as medically necessary (4) Release my treatment information to the health insurance company listed in my health records, for billing purposes (5) Release and receive medically relevant information with authorized legal representatives.

_____ _____

Signature (Patient/Guardian) *Date:*

Weekends Plus Urgent Care

Medical History

Please provide your nurse with this medical history when called back to a room

PATIENT NAME _____

DATE OF BIRTH _____ TODAYS DATE _____

FEMALE PATIENTS ONLY: Are you pregnant or could be pregnant? YES NO

Are you currently breastfeeding? YES NO

Current Medications

(Please list, including over the counter medicines, vitamins & herbs)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
8. _____
9. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____

Drug Allergies

Name of Drug & type of reaction

1. _____
2. _____
3. _____
4. _____
5. _____

Past Surgeries

Surgery When?

1. _____
2. _____
3. _____
4. _____
5. _____

Past Medical History

(Please check the problems you have had)

Allergies (seasonal)	Diabetes	Hepatitis	Vascular Disease
Anemia	Drug Abuse/Addiction	High Blood Pressure	Osteoperosis
Arthritis	Eczema	High Cholesterol	PCOS
Artificial Heart Valve	Gall Bladder Disease	HIV/AIDS	Prostate Problems
Artificial Joints	Gastrointestinal Disease	Joint Surgery	Psoriasis
Asthma	Glaucoma	Keloids	Rosacea
Bleeding Blood Disorder	Gout	Kidney Problems/Stones	Seizure Disorder
Cancer: Type? _____	Hearing/Vision Impairment	Lupus/Auto-immune	Stroke
Congestive Heart Failure	Heart Attack/Stents	Menstrual Disfunction	Thyroid Disease
COPD/Emphysema	Heart Murmur	Migraine Headaches	
Depression	Heart Surgery/Disease	Mitral Valve Prolapse	

Do you have a pacemaker? Yes No If so, when? _____

Do you smoke/vape? Yes No Former Smoker? Yes No What year did you quit? _____

Family History

Is there a family history of cancer? Yes No If yes, what kind? _____

Is there a family history of: Diabetes Yes No, High Blood Pressure Yes No, Heart Disease Yes No,

Stroke Yes No If yes, who? _____

_____ _____

Signature (Patient/Guardian) *Date:*

Weekends Plus Urgent Care Financial Policies

Thank you for choosing us as your primary care/urgent care provider. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this financial policy. We are entering into an agreement with you, with obligations on both sides. Please read it, ask us any questions you may have, and sign in the space provided. Please ask for a copy of this agreement for your records if you would like one. The original will be filed in your chart.

I have received this financial policy, and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts will be referred to a collection service. If it becomes necessary to send my account to a collection service, I agree to pay for all costs and expenses, including reasonable attorney fees.

Signature Date

Patient Name Date of Birth

General

Co-pays: The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in.

Insurance Claims: Billing your insurance is a courtesy service we provide for you. In order to do this, we must receive all the information necessary to bill. If the information is not supplied, you will be billed, and payment in full will be your responsibility. Your insurance coverage is a contract between you and the insurance company**. It is your responsibility to know your insurance benefits. It is your responsibility to notify us of any changes in insurance coverage.**

Referrals and Preauthorizations: 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 or no payment from the insurance company, and the balance will be your responsibility.

Self-pay Accounts: Self-pay accounts are patients without insurance coverage, or patients covered by insurance plans in which the office does not participate. It is always the patient's responsibility to know if our office is participating with their plan. Self-pay patients will be expected to pay in full on the day of visit.
Third Party Billing/Workers' Compensation: We do not do any third-party billing or Workers' Compensation.

Returned Checks: The charge for a returned check is $40 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check. Any check written on a closed account will be presented to the bad check division at the Court House.
Minors: The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

Outstanding Balance Policy: It is our office policy that all past due accounts be sent three statements. If payment is not made on the account, the account will be sent to the collection agency, or attorney, with possible discharge from the practice. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collection costs including attorney fees and court costs, including a $50.00 service fee.

Weekends Plus Urgent care RESERVES THE RIGHT TO CHANGE AND/OR MODIFY THE INFORMATION ON THIS FORM AT ANY TIME.

Submit