BOSWORTH URGENT CARE & GRAND RIVER FAMILY CARE **DATE:**_____

PATIENT REGISTRATION FORM

SECTION 1: DEMOGRAPHIC INFORMATION **(STUDENTS: USE PERMANENT HOME ADDRESS)**

LAST NAME:_____ **FIRST NAME**:_____ **MI**:_____

GENDER: __MALE __ FEMALE **DATE OF BIRTH**:_____ **SOCIAL SECURITY #**: _____

PATIENT ADDRESS: : _____
STREET ADDRESS/APT # *CITY* *STATE* *ZIP CODE*

BILLING ADDRESS:_____ SAME AS ABOVE ☐

CELL PHONE: (_____)_____-_____ **CONSENT TO CALL/TEXT**: YES NO **Preferred Method of Contact**:

CELL HOME WORK

HOME PHONE: (_____)_____-_____ WORK PHONE: (_____)_____-_____

MARITAL STATUS: _____ SPOUSE'S NAME: _____ SPOUSE PHONE: (_____)_____-_____

E-MAIL: _____ **PRIMARY CARE PHYSICIAN**:_____
(IF MINOR, PROVIDE PARENT'S EMAIL)

PREFERED PHARMACY:_____ PRIMARY CARE PHYSICIAN PHONE/LOCATION: _____
Store ***Location***

EMPLOYER: _____ HOW DID YOU HEAR ABOUT US: _____

PLEASE CHECK ALL THAT APPLY:

ETHNICITY
□HISPANIC OR LATINO
□NOT HISPANIC OR LATINO
□DECLINE TO SPECIFY
OTHER: _____

RACE
□WHITE □ASIAN □ DECLINE TO SPECIFY
□AMERICAN INDIAN OR ALASKAN NATIVE
□BLACK OR AFRICAN AMERICAN
□NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

PREFERRED LANGUAGE
□ENGLISH
OTHER: _____

SECTION 2: INSURANCE INFORMATION: CARD NUMBERS NOT NEEDED FOR THIS SECTION

Please present insurance cards at every visit. It is our policy to expect payment at the time of service unless other arrangements have been made.

PRIMARY INSURANCE:_____ **POLICY HOLDER'S EMPLOYER**:_____

POLICY HOLDER'S FULL NAME: _____ **DATE OF BIRTH**:_____
LAST *FIRST* *M.I.*

POLICY HOLDER'S RELATIONSHIP TO PATIENT: SELF LFPOUSE PARENT OTHER

POLICY HOLDER'S ADDRESS:_____ **SAME AS PATIENT** □

SECONDARY INSURANCE: _____ POLICY HOLDER'S EMPLOYER:_____

POLICY HOLDER'S FULL NAME: _____ DATE OF BIRTH:_____
LAST *FIRST* *M.I.*

POLICY HOLDER'S RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT OTHER

POLICY HOLDER'S ADDRESS:_____ SAME AS PATIENT □

SECTION 3: EMERGENCY CONTACT **(PLEASE PROVIDE SOMEONE OTHER THAN SPOUSE)**

Continued on back →

NAME: _____ **PHONE**: (_____)_____-_____ **RELATIONSHIP**:_____

SECTION 4: GUARANTOR INFORMATION (THIS SECTION IS FOR MINORS/DEPENDENTS ONLY)

A Guarantor is the adult accompanying the patient and is responsible for payments/copays for the visit

GUARANTOR FULL NAME:_____ **DATE OF BIRTH**: _____
Last First M.I.

GUARANTOR ADDRESS: _____
Street Address/Apt # City State Zip Code

GUARANTOR'S PHONE #: (_____)_____-_____ **GUARANTOR'S RELATIONSHIP TO PATIENT**:_____

SECTION 5: CONSENT, ASSIGNMENT, RELEASE OF INFORMATION, LABORATORY

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT: Bosworth Urgent Care and/or Grand River Family Care have made their "Notice of Privacy Practices" document available to me. (Copy located underneath TV in waiting room).

PHARMACY MEDICATION HISTORY: I, the undersigned patient, parent or guardian of a patient, authorizes Bosworth Urgent Care and/or Grand River Family Care to access my Medication History from my pharmacy.

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY/INFORMATION RELEASE:
I authorize payment of medical benefits to Bosworth Urgent Care and/or Grand River Family Care for any services furnished to me by them. I understand that I am financially responsible for any amount not covered by my insurance carrier (i.e. co-payments, deductibles, co-insurance or non-covered services, including non-covered services by Medicaid). I also authorize you to release to my insurance carrier or their agent(s), information concerning health care, advice, treatment or supplied or provided to me. This information will be used for the purpose of evaluating and administering claim benefits. I understand that if my account is turned over to a collections agency, I will be financially responsible for the payment of collection fees above the regular balance owed. Tier 1 collection fee assessed will be $50.00. Tier 2 collection fee assessed will be $75.00.

LABORATORY: Most laboratory tests are done at an outside lab (i.e. Sparrow, Quest). Please be aware that there will be a separate bill from the lab for these services. If your insurance company requires that laboratory tests be performed at a designated facility, you will need to inform us of this requirement each time lab tests are being ordered. You are ultimately responsible for compliance with your insurance rules and requirements or for any charges related to lab work.

I have read and consent to all items in Section 5.

SIGNATURE:_____ **DATE:**_____
(Patient, Parent or Legal Guardian if patient is minor)

SECTION 6: PATIENT COMMUNICATIONS

I consent to the release of my protected health information over the telephone to the following individuals:

1.) Name of person:_____Relationship:_____Cell Phone: (_____)_____-_____
2.) Name of person:_____Relationship:_____Cell Phone: (_____)_____-_____

SECTION 7: REQUEST AND CONSENT FOR TREATMENT/CARE OF MINOR CHILD

I understand that my child should be accompanied by a parent/guardian at any time he/she appears for treatment and as such will make every effort to be present. On those occasions when it is not possible for me to accompany my child, I request that the practice/physician provide treatment, as authorized by the person(s) listed below. I further understand that if transfer of my child to a hospital/emergency room is necessary, I authorize the persons listed below to consent for the hospital/ER transfer for my child in my absence. I understand that by permitting my child to appear at Bosworth Urgent Care/GRFC, without my presence, I will obtain information regarding this care from the person(s) listed below or the practice after the care has been provided. **I have listed the person(s) below who are authorized to bring my child to the practice in my absence and to consent for treatment on behalf of my child. (Note: The person designated to consent for treatment for the minor child must be at least 18 years old.)**

1.) _____ 2.) _____ 3.) _____
(Print Name) (Print Name) (Print Name)

CONSENT FOR TREATMENT OF A MATURE MINOR: I understand that if my child is 16 years or older I may request and authorize treatment/care of my mature minor without my presence. By signing below, I give my permission for my mature minor to obtain treatment/care without my presence. It is my responsibility to obtain information from the practice or child regarding the treatment/care provided.

SIGNATURE:_____ **DATE:**_____