

**BOSWORTH URGENT CARE & GRAND RIVER FAMILY CARE**  
**PATIENT REGISTRATION FORM**

**DATE:** \_\_\_\_\_

**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)

**PRIMARY CARE PHYSICIAN**

**PREFERRED PHARMACY:** \_\_\_\_\_ **PHONE/LOCATION:** \_\_\_\_\_  
*Store Location*

**EMPLOYER:** \_\_\_\_\_ **HOW DID YOU HEAR ABOUT US:** \_\_\_\_\_

**PLEASE CHECK ALL THAT APPLY:** **ETHNICITY** **RACE**  
 HISPANIC OR LATINO  WHITE  ASIAN  DECLINE TO SPECIFY  
**PREFERRED LANGUAGE**  NOT HISPANIC OR LATINO  AMERICAN INDIAN OR ALASKAN NATIVE  
 ENGLISH  DECLINE TO SPECIFY  BLACK OR AFRICAN AMERICAN  
**OTHER:** \_\_\_\_\_ **OTHER:** \_\_\_\_\_  NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

**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 SPOUSE 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)**

**NAME:** \_\_\_\_\_ **PHONE:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_

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**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, their agent(s), and/or my Primary Care Physician information concerning my health care, office visit notes, 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:** \_\_\_\_\_