FASTER CARE

PATIENT REGISTRATION

PATIENT NUMBER

Patient Information

LAST NAME _____

FIRST NAME _____ MI ___

DATE OF BIRTH ____ / ____ / ____ SEX _____

RACE _____

MARITAL STATUS □ MARRIED □ SINGLE

□ DIVORCED □ WIDOWED

SSN#: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

_____

EMPLOYER _____

HOME ADDRESS _____

_____

CITY _____ STATE _____ ZIP _____

HOME PHONE (__ __ __) ___ ___ ___ - ___ ___ ___ ___

CELL PHONE (__ __ __) ___ ___ ___ - ___ ___ ___ ____

WORK (__ __ __) ___ ___ ___ - ___ ___ ___ ___

PRIMARY PHYSICIAN _____

HOW DID YOU HEAR ABOUT US: _____

EMERGENCY CONTACT

Name:_____ Phone: _____

FINANCIALLY RESPONSIBLE PARTY

(PARTY MUST BE PRESENT TO PROVIDE SIGNATURE IN ORDER TO ACCEPT FINANCIAL RESPONSIBILITY)

CHECK HERE IF SAME AS PATIENT AND SKIP TO NEXT SECTION

RESPONSIBLE PARTY'S NAME:_____ DATE OF BIRTH:_____

ADDRESS (IF DIFFERENT):_____CITY:_____ STATE:_____ ZIP:_____

SOCIAL SECURITY #_____PHONE:_____ SIGNATURE:_____ DATE: _____

INSURANCE POLICY HOLDER (THE INDIVIDUAL WHOSE NAME THE INSURANCE IS UNDER) **PATIENT**

RELATIONSHIP _____

LAST NAME_____

FIRST NAME_____ MI _____

DATE OF BIRTH ____ / ____ / _____

SSN # ___ ___ ___ - ___ ___ - ___ ___ ___ ___

PH : (__ __ __) ___ ___ ___ - ___ ___ __ ___

ADDRESS _____

CITY _____STATE _____ ZIP _____

EMPLOYER _____

ADDRESS _____

PH: (__ __ __) ___ ___ ___ - ___ ___ ___ ____

Please read and sign the four statements below. Providing your signature acknowledges that you have read, understood, and are agreeable.

If you have any questions regarding any of these statements please ask the receptionist before providing your signature. Thank you.

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I also authorize Faster Care or my insurance company to release any information required to process my claims. I consent to treatment by the physicians of Faster Care and to appropriate tests for the presence of infection, such as, but not limited to Hepatitis B Virus, Hepatitis C Virus, or HIV if deemed necessary and authorize the withdrawal of blood or other body fluids for this purpose.	**X** → **Signature** (patient or parent if patient is a minor) **Date**
RECEIPT OF NOTICE OF PRIVACY PRACTICES: I verify that I have received a copy of Faster Care's notice of privacy practices.	**X** → **Signature** (patient or parent if patient is a minor) **Date**
I am aware that ALL radiographic studies including but not limited to x-rays, cat scans and ultra sounds will be read by a radiologist who will require a separate payment. All laboratory procedures not executed at Faster Care will also require a separate payment. The patient will be responsible for these charges, not Faster Care.	**X** → **Signature** (patient or parent if patient is a minor) **Date**
Payment for the patient portion will be collected at the time of service; including co-pays, coinsurance, and any portions of your unpaid deductible. Collection accounts will receive a $50.00 charge on all unpaid balances. Bounced checks will receive a $30.00 charge.	**X** → **Signature** (patient or parent if patient is a minor) **Date**