GATEWAY URGENT CARE

				Today's Date:
Patient Information:	Last: First: MI:			Preferred Name (If different):
	DOB:	Gender: ☐ M ☐ F	SSN:	Previous Last Name:
Billing Address:	Street: City: State: Zip:			
	Apartment Number: Cell Phone: ( ) Consent to receive text messages?* YES NO			
	Home Phone: ( ) Email:			
	Other family members who are patients in our clinic:			
Today's Visit:	Reason for today's visit: _____			
Guarantor/ Responsible Party (if patient is under 18 years old):	Last: First: MI:			
	Address:			
	SSN:	DOB:	Gender: ☐ M ☐ F	
	Cell Phone: ( )	☐ Parent ☐ Spouse ☐ Legal Guardian ☐ Other		
Patient's Marital Status:	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed			
Patient's Language:	☐ English ☐ Spanish ☐ French ☐ Arabic ☐ Decline ☐ Other: _____			
Patient's Race:	☐ Decline ☐ Black or African American ☐ Asian ☐ American Indian or Alaskan Native ☐ White ☐ Other (please specify) _____			
Patient's Ethnicity:	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Decline to specify			
Pharmacy:	Name: Address:			
Patient's Employment Status	☐ Currently working ☐ Not Working ☐ Student ☐ Retired ☐ Disabled			
Primary Insurance:	Insurance Company Name:			
	Policy Holder's Name Last: First: MI:			
	SSN:	DOB:	Relation to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other	
	Subscriber ID:	Group ID:		

Secondary Insurance:	Insurance Company Name:		
	Policy Holder's Name Last: First: MI:		
	SSN:	DOB:	Relation to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other
	Subscriber ID:	Group ID:	

Financial Agreement:

- I acknowledge that, as a courtesy, GATEWAY HEALTHCARE may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to, co-payments, co-insurance, deductibles and/or charges not covered by insurance.
- I understand there is a $25 fee for returned checks.

Third Party Collection: I understand GATEWAY HEALTHCARE may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits: I hereby assign to GATEWAY HEALTHCARE any insurance or other third-party benefits available for health care services provided to me. I understand GATEWAY HEALTHCARE has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to GATEWAY HEALTHCARE, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit: I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to GATEWAY HEALTHCARE by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communication: I agree that, in order for GATEWAY HEALTHCARE, EBO and/or collection agencies to service my account or to collect any amounts I may owe, I expressly agree and consent that GATEWAY HEALTHCARE and/or EBO and/or collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided, or GATEWAY HEALTHCARE, EBO and/or collection agents have obtained, or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature _____ Date _____

If you are not the patient, please circle your relationship to the patient. Spouse Parent

Legal Guardian Guarantor Healthcare Power of Attorney Other _____

Do you have any health information that you would like to be kept confidential from any person or persons? If so, please specifically describe the information and person or persons below:

☐ Yes ☐ No Name: _____

Patient Name: _____ DOB: _____ / _____ / _____

Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health information? This person(s) will also be your emergency contact. (Check all that apply)

		Name	**Telephone**
☐	Spouse	_____	_____
☐	Caretaker	_____	_____
☐	Child	_____	_____
☐	Parent	_____	_____
☐	Other	_____	_____

***Consent to Receive Text Messages -** I authorize Gateway Urgent Care (GUC) to contact me by SMS text message for health-related notifications and/or appointment reminders. I understand that message/data rates may apply. I know I am under no obligation to authorize GUC to send text messages and may opt out at any time.

I acknowledge full financial responsibility for services rendered by Gateway Urgent Care (GUC). I understand I am responsible for prompt payment of all amounts due, including but not limited to, co-pays, deductibles, and co-insurance amounts. I understand that payment of co-pays, deductibles and insurance amounts are expected at time of service, as well as any prior balances owed. I also consent that payment of authorized insurance benefits may be made on my behalf directly to GUC for any medical services provided. I agree to be responsible for all reasonable attorney's fees and collection costs in the event of default.

I authorize GUC medical staff to render medical treatment and evaluation needed. I further authorize orders of X-Rays, injections, casting or other diagnostic tests and treatment that may be necessary to diagnose and treat my illness or injuries. I hereby give my consent to GUC to use or disclose, for the purpose of carrying out treatment, payment or healthcare operations, all protected healthcare information, payment or healthcare operations, all protected healthcare information contained in this patient record.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice. I also understand that I will not be able to revoke this consent in cases where my provider has referred to it for purposes of disclosing my health information. Written revocation of consent must be sent to the urgent care office, attention: Practice Manager.

I have reviewed or had the opportunity to review Gateway Urgent Care's HIPAA policy and privacy practices.

Signed _____ Date _____

If you are not the patient, please specify your relationship to the patient _____