

# Occumed Walk In & Urgent Care, PLLC

530 NORTH ELAM AVE. STE C

GREENSBORO, NC 27403 (336)574-0707

DATE: \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_

PATIENT NAME:(FIRST) \_\_\_\_\_ (MIDDLE) \_\_\_\_\_ (LAST) \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT. \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HOME TELEPHONE:( ) \_\_\_\_\_ CELL: ( ) \_\_\_\_\_ DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_

AGE: \_\_\_\_\_ SEX:(CIRCLE ONE) MALE FEMALE SOCIAL SECURITY NUMBER: \_\_\_-\_\_\_-\_\_\_

MARITAL STATUS:(CIRCLE) SINGLE MARRIED DIVORCED WIDOWED EMPLOYED: YES / NO

EMPLOYER: \_\_\_\_\_ PHONE \_\_\_\_\_

SPOUSE EMPLOYER: \_\_\_\_\_ PHONE \_\_\_\_\_

IF PATIENT IS A MINOR, PARENTS NAME: \_\_\_\_\_

HOW WERE YOU REFERRED TO OCCUMED WALK IN & URGENT CARE? FRIEND \_\_\_ EMPLOYER \_\_\_

INTERNET \_\_\_ PHYSICIAN \_\_\_ PHONEBOOK \_\_\_ WEBPAGE \_\_\_ OTHER \_\_\_

## FINANCIAL POLICY

Occumed Walk In & Urgent Care, PLLC is a **In Network Provider** with my Insurance Company. I agree that the Insurance benefits obtained by the provider from my insurance carrier is **not a guarantee of payment**. I understand that copays, deductibles and any non-covered services are my responsibility and payable at the time of service. A representative at Occumed Walk In & Urgent Care, PLLC has communicated my benefits and has explained my financial responsibility and I agree to the financial policy as outlined.

Patient Signature/Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

## FINANCIAL POLICY

Occumed Walk In & Urgent Care, PLLC is a provider of medical services for **EMPLOYEES INJURED ON THE JOB**. I understand that the medical services received as a result of my injury on the job may not be covered under Worker's Compensation insurance. I understand that I am ultimately responsible for the services received at Occumed Walk In & Urgent Care, PLLC. A representative of Occumed Walk In & Urgent Care, PLLC has notified me of my financial responsibility and I agree to the financial policy as outlined.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## FINANCIAL POLICY

I am a patient presented for services **WITHOUT INSURANCE OR OUT OF NETWORK INSURANCE**. I understand all services have to be paid at the time of service.

Patient Signature / Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

**NO INSURANCE? HIGH DEDUCTIBLE? WE CARE. ASK ABOUT OUR "WE CARE" MEDICAL DISCOUNT CARD.**

**RELEASE OF MEDICAL INFORMATION FOR COORDINATION OF CARE**

I, hereby authorize Occumed Walk In & Urgent Care, PLLC to release medical information to my referring physician, primary care doctor, case manager and any other individual involved in my medical care for the sole purpose of facilitating my treatment. I understand that my medical information is confidential and that I have a choice to request that my physician not share my medical records with any of the individuals. Should I choose to exercise this right, I will provide in writing to my physician any of the individuals involved in my care to which I do not wish to receive my medical records. I agree that a copy of this release may be used in place of the original. I am aware that I may request that this Release of Medical Information may be revoked at any time by providing the physician's office with a dated and signed letter. I have read and agree to these terms.

Patient or Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I, hereby authorize Occumed Walk In & Urgent Care, PLLC to communicate to the following persons my protected health information. You have the right to change the persons authorized to receive health information about you at any time you request. Our office has to be notified in person to add or change the authorized persons listed on this document.

\_\_\_\_\_  
Name Relationship to patient

\_\_\_\_\_  
Name Relationship to patient

Contact Person In Emergency: \_\_\_\_\_ Phone: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

NOTE: Any request for medical records must be made in person. Our office reserves the right to release medical records with a 30 day notice and the right to make medical records available to a patient upon 30 days from the date of recorded request. There is a fee of \$10.00 for copies of medical records up to the first 25 pages.

***"WE CARE."  
NO INSURANCE. HIGH DEDUCTIBLE.  
ASK ABOUT OUR "WE CARE" MEDICAL DISCOUNT CARD.***