READY CLINIC FAMILY PRACTICE

Ready Clinic
Walk In & Family Medicine

Patient Information

Legal First Name _____ Legal Last Name _____ Preferred First Name _____

Male/Female _____ Date of Birth _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Email Address _____

Mobile Phone _____ Home Phone _____ Work Phone _____

Employer _____

Preferred Pharmacy _____ How did you hear about us? _____

Can we retrieve your prescription history from your pharmacy? Yes No

Responsible Party's Information/Guarantor: _____ _____

Inital here if same as above Initial here is different that patients

Name _____ Relationship to Patient _____

Social Security # _____ Date of Birth _____

Address _____ Phone # _____

Ethnicity (Circle) Hispanic Latino Non-Hispanic

Race (Circle) American Indian Asian Black/African American
Native Hawaiian or Other Pacific Islander White Other

Name of Emergency Contact/Next of Kin _____

Relationship to Patient _____ Phone # _____

Insurance Information

Please present your insurance card and ID with this form if you have not already done so.

Primary Insurance Plan Name _____ Policy Holder S.S.# _____

Secondary Insurance Plan Name (If applicable) _____

If policy holder name is different than patient, please fill out below.

Policy Holder _____ Policy Holder Date of Birth _____ Relationship to patient _____

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, finding and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			

Patient may revoke or modify this specific authorization and that revocation or modification must be in writting.

In the event we are unable to reach you by phone, may we leave a detailed message on your voice mail? Yes No

_____
Sign

READY CLINIC
FAMILY PRACTICE

READY CLINIC CONSENT FOR TREATMENT

Patient's Name (print legibly): _____

Patient's Date of Birth: _____

Patient's Age: _____

1. **CONSENT TO TREAT**: I authorize my treating physician and other healthcare providers to order for me all forms of diagnostic testing and treatment which they judge to be appropriate. I request and authorize Ready Clinic and its agents and employees, to provide all treatment services to me as directed by my physicians. I acknowledge that no representation or guarantees have been made to me as a result of the treatment of care.

2. **ASSIGNMENT AND RELEASE**: I hereby certify that the insurance information I have provided is accurate, complete, and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize my provider to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay my provider directly, I agree to forward to my provider all health insurance payments which I receive for services rendered by my provider and its health care providers. In the event of default of payment, I agree to pay a thirty (30) percent fee, including attorney's fees. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this Signature on all my insurance submissions.

3. **FINANCIAL AGREEMENT**: I will make every effort to actively assist Ready Clinic with securing payment for services rendered for which I am liable. If I am the parent/guardian of a minor patient, I understand that unless addressed in my third-party payer agreements, I am financially responsible for all services rendered, and that the parent who authorizes treatment will be responsible for any balance due. I understand that Ready Clinic submits claims to insurance carriers to assist its patients and that I am responsible for the balance owed at any time unless other arrangements have been made. I understand that I do not provide sufficient and timely information and releases of information for Ready Clinic to process insurance claims, I will be responsible to pay Ready Clinic full and standard fees.

4. **CONTROLLED MEDICATION POLICY ACKNOWLEDGEMENT**
I understand that Ready Clinic is primarily staffed with nurse practitioners. In the state of GA, a nurse practitioner cannot order/prescribe Schedule II narcotics, therefore, these will not be written unless the MD sees me and prescribes them to me. I further understand that no other controlled substance will be called in after normal hours of the clinic. I also agree to comply with all state and federal regulations regarding random drug testing as well as being seen intermittently by the MD for any scheduled medications that are written by the NP. If requirements are not met, I understand that refills will not be given.

5. **HIPAA**: I acknowledge that I have received or have been provided the opportunity to receive a copy of the "Notice of Privacy Practices." I understand the Notice of Privacy may change over time and that the obligations of Ready Clinic and my rights under it may change. **Initial**: _____

_____	_____	___/___/___
Printed Name of Patient/Authorized Representative	Signature of Patient/Authorized Representative	Date

If the Patient is under the age of 18, a parent or legal guardian of the Patient must complete and sign this