620 Dr. Calvin Jones Highway, Suite 212
Wake Forest, NC 27587
P: 919-761-5678 / Fax: 919-761-5680

Please fill out and sign all registration paperwork attached.
This will help us better serve you during your time at our clinic.

PATIENT REGISTRATION

Today's Date: _____/_____/_____

Last Name: _____ First Name: _____ M.I. _____

Date of Birth: _____/_____/_____ Age: _____ SSN: _____-_____-_____

Gender: [ ] Male [ ] Female Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____Email Address_____

Employer: _____ Employer Address: _____

Pharmacy: _____

Pharmacy Address: _____ Phone Number: _____

How did you hear about us? _____
We would love to thank them!

INFORMATION FOR MINORS

This section is REQUIRED for treatment of all minors.
Please list names of any person who may have access to patient's information.

Name: _____ Relationship to Patient: _____

Date of Birth:_____ Phone Number: _____

Name: _____ Relationship to Patient: _____

Date of Birth:_____ Phone Number: _____

Name: _____ Relationship to Patient: _____

Date of Birth:_____ Phone Number: _____

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INSURANCE INFORMATION

(Please complete all that apply)

Primary Insurance Provider: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: ____/____/____

Member ID: _____ Group Number: _____

Secondary Insurance Provider: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: ____/____/____

Member ID: _____ Group Number: _____

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PATIENT FINANCIAL POLICY

Thank you for choosing Heritage Urgent & Primary Care. While your health and well-being is our primary concern, we realize that the cost of healthcare is an issue for many patients. We offer the following information to help you understand our financial policies and aid you in planning for payment. Carefully review the information and please ask our staff if you have any questions.

INSURANCE

It is your responsibility to provide Heritage Urgent & Primary Care with current insurance information. We will ask you for your insurance card at your first visit and keep a copy for your records. We may request a copy at a later date in order to update your records, so please bring your insurance card to each visit. We will help you receive the maximum benefits your insurance allows, however, please remember that your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your claims for you and provide necessary information, including primary and secondary insurance information changes, to your insurance company. Failure to provide complete insurance information may results in reduced insurance benefits for you.

Not all services are covered through all insurance plans. Some health plans select certain services that they will cover. Your insurance company will make the final determination of your eligibility and benefits. In the even that your health plan determines a service to be “not covered”, you will be responsible for the entire charge. Also, please be aware that if we are out-of-network for benefits, you will receive a bill and be responsible for the remaining balance. This balance is due upon receipt of your statement. In the event that you are unable to pay the balance in full, we encourage you to promptly contact our billing office at 866-557-2612 for assistance in creating a payment plan. Be aware that if your treatment requires biopsy or culture, you may receive a bill from a third party.

CO-PAYS

Co-payments may be required by your insurance plan. All co-payments must be paid prior to your appointment at check in. If you do not have your co-payment, your appointment may be rescheduled.

DEDUCTIBLES AND COINSURANCE

For patients who have insurance plans that have applicable deductibles and coinsurance, be aware that you will be responsible for payment of the deductible or coinsurance applicable to procedures. It is also the patient’s responsibility to check with insurance carrier concerning deductibles and coinsurance.

SELF-PAY ACCOUNTS

Self-pay accounts are for patients without insurance coverage. It may also include patients covered by insurance plans that Heritage Urgent & Primary Care is not in network with or patients without an insurance card on file. It is your responsibility to know if care at Heritage Urgent & Primary Care is covered by your plan. If there is a discrepancy of your information, you will be considered a self-pay patient until you provide information proving otherwise.

PAST DUE ACCOUNTS

If your account is part due, please contact the billing office at 866-557-2612, so that we can assist you with a payment plan. If your account has been referred to a collection agency or attorney, you must pay the balance in full, including any collection fees. If you require further treatment and your account is in collections, the full balance will be due, and you will be required to pay the cost of the next visit in full, prior to being seen.

RETURNED CHECKS

A fee may be required for returned checks. This amount will be applied to your account, in addition to the insufficient funds amount. Your account may be assigned "self-pay" status, requiring upfront payments following a returned check.

REFERRALS & PRE-AUTHORIZATIONS/NOTIFICATIONS/CERTIFICATES

Your insurance company may require a referral from another physician and/or a pre-authorization, notification, or certification. While it is your responsibility to obtain these, someone in the office will help you if necessary. Please make sure that all referrals are in our office prior to your visit. Failure to obtain these may result in a lower payment or no payment from your insurance company, and the balance will be your responsibility.

MINORS

The parent(s) or guardian(s) presenting the child for treatment is responsible for full payment and will receive the billing statements. In addition, we may pursue payment from a non-custodial parent of guardian.

PATIENT AUTHORIZATION, ACKNOWLEDGEMENT, AND AGREEMENT

I hereby authorize payment of health insurance benefits and, if applicable, government benefits directly to Heritage Urgent & Primary Care for services provided to me. I authorize the release of my healthcare information necessary to process my claims. I further authorize the release of my healthcare information to other healthcare providers, hospitals, and facilities involved in my treatment.

I understand, acknowledge, and agree that I am financially responsible for my deductible, co-pay, coinsurance, and any amount exceeding what my insurance company pays, except where exempt by contractual agreement. I understand that I am financially responsible for any balance remaining after my claim has been processed. I further upstand that I am responsible for complying with any requirements that my insurance carrier may have regarding referrals, prior approvals, and pre-authorizations.

I HAVE READ THE PATIENT FINANCIAL POLICY AND/OR IT HAS BEEN FULLY ERXPLAINED TO ME. I CERTIFY THAT I UNDERSTAND ITS CONTENTS, AND THATI AM COMPETENT TO EXECUTE IT OR THAT I AM AUTHORIZED TO EXECUTE IT ON THE PATIENT'S BEHALF.

Print Patient's Name: _____

Signature: _____ Date: _____

Parent/Guardian Name (if applicable): _____

Parent/Guardian Signature: _____

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NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered or received a copy of Heritage Urgent and Primary Care's NOTICE OF PRIMARY PRACTICES. I understand that Heritage Urgent & Primary Care is a healthcare provider and may share my health information for treatment, payment, and healthcare operations. I understand that if I have questions of concerns regarding my privacy rights, I may send correspondence in writing or by phone to:

Raleigh Durham Medical Group
5420 Wade Park Blvd, Suite 106
Raleigh, NC 27607-4189
P: 919-782-1806

PLEASE NOTE: ALL COMPLAINTS MUST BE IN WRITING

I further understand that if the NOTE OF PRIVACY PRACTICES should be amended, modified, or changed, I will be notified at my next visit.

Patient OR Guardian Signature: _____ Date: _____

CANCELLATION AND NO SHOW POLICY

We understand that situation arise that may require cancellation of your appointment. It is therefore requested that if you must cancel, please give us a 24-hour notice. This will enable other patients who are waiting for appointments to be scheduled in your slot.

Appointments that are cancelled with less than a 24-hour notification may be subject to a $35 cancellation fee.

Patient who do not show up for their scheduled appointment without a 24-hour cancellation notice are considered a NO SHOW and will be charged at $35 NO SHOW fee.

The cancellation and NO SHOW fees are the sole responsibility of the patient and must be paid in full before the patient can be seen again.

We understand that special circumstances may arise and cause you to cancel with less than a 24-hour notification. In this case, the cancellation fee MAY be waived by management approval.

Heritage Urgent & Primary Care believes that a good provider/patient relationship is based upon understanding and communication. Please sign below that you have read, understand, and agree to our Cancellation and No Show Policy.

Patient OR Guardian Signature: _____ Date: _____

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Authorization for Release of Information

Patient Name: _____ Date of Birth: _____/_____/_____ SSN: _____-_____-_____

Authorization:

1. I, _____, hereby authorize:
   (Patient Name)

2. HERITAGE URGENT & PRIMARY CARE
   620 Dr. Calvin Jones Hwy, Ste 212
   Wake Forest, NC 27587
   P: 919-761-5678

3. To release and/or discuss the following information (check boxes that apply):
   [ ] Complete records [ ] Outpatient care [ ] Inpatient care
   [ ] X-Ray results [ ] Laboratory results [ ] Treatment plan updates
   [ ] Other: _____
   *If my records contain the following information, it is released IF CHECKED in boxes below:
   [ ] Substance abuse treatment [ ] Mental health treatment [ ] STD/HIV testing/treatment

4. To the following individual/business/doctor's office:

   Name: _____

   Address: _____

   City: _____ State: _____ Zip Code:_____

   Relation to patient: _____

This authorization expires [ ] Six month / [ ] One year from today's date OR upon the following specified event:
_____

I have carefully read and understand the above information and consent to its disclosure. I am aware that information regarding my medical condition will be released to the person(s)/organization(s) named above. I understand that if the person(s) or organization(s) that I have authorized to receive my protected health information are not subject to federal and state health information privacy laws. Subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

I understand that this consent is subject to revocation, in writing, at any time, unless action based has already begun.
I authorize the use of a copy of this form for the disclosure of the information described above.

Signed: _____ Date: _____