



Patient Registration

Patient Name _____ Social Security# _____

Address _____ City _____ State _____ Zip _____

Home # _____ Alternate # _____ Cell # _____

M ___ F ___ Age _____ DOB: _____ Marital Status: Single ___ Married ___ Widowed ___ Divorced ___

Employer _____ Occupation _____ Work # _____

Personal MD _____ Emergency contact _____

How would you like us to contact you for follow up calls and/or lab results?

Phone: leave message _____ mail _____ other _____ e-mail _____

Guarantor Information (Responsible Party)

If patient and guarantor are same check here _____ Relationship to patient _____

Name _____ Guarantor Social Security # _____

Address (if different from patient) _____

Guarantor's DOB _____ Employed by _____ Phone# _____

Insurance Information

Primary Insurance Company _____

Subscriber name _____

ID # _____ Group number or name _____

Secondary Insurance Company _____

Subscriber name _____

ID # _____ Group number or name _____

Information Release

In order to share any of your medical information with another person, you must write their name and relationship below. Without this authorization, Valley Immediate Care will not release any of your medical information. You may revoke this release at any time.

Name & Relationship (spouse, parent, etc.)

Financial Agreement

Fees for office visit are determined by the complexity of the medical problem, the time spent with the patient, and when indicated, the use of lab, medications, x-ray or specialty procedures and supplies. The responsibility for payment for services rendered ultimately rests with the responsible party indicated above. Valley Immediate Care accepts cash, checks, and most major credit cards. All balances are due at the time of service. If payment arrangements are needed these must be established prior to receiving services. Valley Immediate Care will bill selected insurance carriers for covered services. You must provide all necessary information prior to your treatment. If elected to have your insurance company billed, you will be required to pay for any co-pays or deductibles at the time of service. Valley Immediate Care will make every attempt to verify your insurance eligibility prior to your visit. However, If service coverage cannot be verified you will be responsible for all charges incurred at the time of service. If you desire to file your insurance claim, Valley Immediate Care will provide you with all forms necessary to do so. This includes HCFA 1500 Claim Form and a copy of your visit information.

It is your responsibility to make payments on any balances owed. If you are having problems paying your bill, please contact our billing office and make arrangements regarding timely payments. Unpaid service charges may be referred to a collection agency for legal action, which may adversely affect your credit rating and availability of services.

Laboratory Charge Policy

Some of the samples drawn or collected today may be forwarded to RVMC Lab for further testing. We would like to notify you of a separate charge from RVMC for this service.

Patient Non-Disclosure Statement

Some medications that may be needed for treatment may be available for purchase on-site. However, I understand that I will always be given the option for a written prescription that I can take to a pharmacy of my choice.

Acknowledgement of Notice of Privacy Practice

I understand that Valley Immediate Care will use and disclose health information about me in the course of providing medical care to me. I understand that my health information may include information both created and received by the clinic, may be in the form of written or electronic records or spoken word, and may include information about my health history, health status, symptoms, examinations, test results, diagnosis, treatment, procedures, prescriptions and similar health-related information. I understand that the clinic is permitted to use and disclose my health information in order to:

- ✓ Make decisions about and plan for my care or treatment;
- ✓ Refer to/or consult and coordinate with other health care providers in the course of my treatment;
- ✓ Determine my eligibility for health plan or insurance coverage, and submit bills, claims, and other related information to insurance companies and others who may be responsible to pay for some or all of my health care;
- ✓ Perform various office, administrative and business functions that support the clinic's ability to provide me with appropriate care, including provision of medical supplies and equipment and arrange for payment.

I understand that the Notice of Privacy Practice describes how I can exercise my right to ask that some or all of my health information not be used or disclosed. A copy of the clinic's Notice of Privacy Practice is available to you.

By signing you understand and agree to all of the above stated.

Patient/Guarantor Signature X _____ Date _____

North Medford Medical Clinic
1600 Delta Waters Rd, Ste 107
Medford, OR 97504-9114
Tel: 541-858-2515

South Medford Medical Clinic
235 Barnett Rd, Ste 106
Medford, OR 97501-7903
Tel: 541-773-4029

Grants Pass Medical Clinic
162 NE Beacon Dr, Ste 103
Grants Pass, OR 97526
Tel: 541-479-1090