Urgent Care Hawaii
where amazing healthcare happens

MOTOR VEHICLE ACCIDENT (MVA) REGISTRATION FORM

PATIENT REGISTRATION

Patient Name:_____
First *Middle* *Last*

Home Number:_____ Cell Number:_____

Home Address:_____
Street Address *City/State/Zip Code*

Date of Birth:_____ SSN:_____

Accident Date:_____ **Were you the:** ❒ Passenger ❒ Driver

HAVE YOU BEEN TO ANY DOCTOR(S) OFFICE OR HOSPITAL BEFORE TODAY? ❑ YES ❑ NO

Please describe what happened:

_____

_____

_____

PATIENT'S AUTO INSURANCE COMPANY/PIP

Insurance Name:_____

Policy Number:_____ Claim Number:_____

Insured's Name:_____ Relationship:_____ SSN:_____

Insured's Address:_____
Street Address *City/State/Zip Code*

Date of Birth:____/____/____ Home Phone:_____ Cell:_____

Attorney Name:_____ Phone:_____

DRIVER'S AUTO INSURANCE COMPANY/PIP

Insurance Name:_____

Policy Number:_____ Claim Number:_____

Insured's Name:_____ Relationship:_____ SSN:_____

Insured's Address:_____
Street Address *City/State/Zip Code*

Date of Birth:____/____/____ Home Phone:_____ Cell:_____

Attorney Name:_____ Phone:_____

PATIENT'S HEALTH INSURANCE

Insurance Name:_____

Insured Name:_____ Relationship to Patient:_____

Insured's SSN:_____ Group Number:_____

Insurance Company Phone Number:_____ Deductible:_____ Met: ❑ YES ❑ NO

_____ _____ _____
Signature of Patient (or Responsible Party) *Date* *Signature of Other Responsible Party*

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ASSIGNMENT OF BENEFITS

Financial Responsibility
All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits
I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to URGENT CARE HAWAII, LLC for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information
I hereby authorize URGENT CARE HAWAII, LLC to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.
I have requested medical services from URGENT CARE HAWAII, LLC on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____
Signature of Patient or Responsible Party (If a minor) *Date*

FOR OFFICE USE ONLY

PIP INSURANCE COMPANY:_____ **PHONE#:**_____

ADJUSTER:_____ **3RD PARTY CLAIM REPRESENTED:** ❑ YES ❑ NO

CLAIMS ADDRESS:_____

CLAIM#_____

HOW MANY VISITS ALLOWED AFTER INITIAL VISIT?_____

VERIFIED BY:_____**DATE:**_____