Urgent Care Hawaii
where amazing healthcare happens

WORKERS COMPENSATION REGISTRATION FORM

PATIENT INFORMATION

SSN:_____ First Name:_____ Last Name:_____

Date of Birth:____/____/____ Address:_____

Sex: ❑ M OR ❑ F City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

How did you hear about us? ❑ Established ❑ Friend/Family ❑ Insurance ❑ Employer ❑ Other (*Please specify*) _____
❑ Event ❑ Doctor Referral ❑ Internet ❑ Drive By

Preferred Pharmacy Location:_____

**Please indicate the specific location and city of your preferred pharmacy.*

Race:_____ Preferred Language:_____ Hispanic/Latino: ❑ Y OR ❑ NO

EMERGENCY CONTACT

Name:_____ Relationship:_____ Phone Number:_____

EMPLOYERS INFORMATION

Company Name:_____ Contact Name:_____

Company Address:_____

Phone Number:_____ Ext:_____ Fax Number:_____

DESCRIPTION OF INJURY

Were you injured at work? ❑ YES or ❑ NO **Date of Injury:**_____

Drug Screen: ❑ YES or ❑ NO **Injured Body Part:**_____

In a short summary please describe what happened:

_____

_____

WORKERS COMPENSATION INSURANCE CARRIER

Insurance Carrier:_____

Insurance Address:_____

Adjuster's Name:_____

Phone Number:_____ Ext.:_____ Fax Number:_____

Claim Number (if applicable):_____

I certify that the above information is true and correct. It is my responsibility to contact my employer and authorize all new and follow up visits. I acknowledge that Urgent Care Hawaii, LLC will bill Workers' Compensation insurance for all my claims. **If my Workers' compensation claim is denied I am financially responsible for any and all my accounts with Urgent Care Hawaii, LLC.**

Signature:_____ **Date:**_____

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PERSONAL INSURANCE COVERAGE

Primary Insurance:_____ Secondary Insurance:_____

Name of Policy Holder:_____ Name of Policy Holder:_____

Name of Policy Holder:_____ Name of Policy Holder:_____

Group Number:_____ Group Number:_____

Policy Holder SSN:_____ DOB:____/___/___ Policy Holder SSN:_____ DOB:____/___/___

Relationship to Patient:_____ Relationship to Patient:_____

GUARANTOR'S INFORMATION (Please complete for patients under the age of 18)

Name:_____

Address:_____

Street Address *City/State/Zip Code*

Urgent Care Hawaii, LLC, appreciates the confidence you have shown in choosing us to provide for your healthcare needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Urgent Care Hawaii, LLC, for providing services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Urgent Care Hawaii, LLC, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

If I do not have health insurance and will be responsible for services rendered here at Urgent Care Hawaii, LLC. I agree to pay Urgent Care Hawaii, LLC, the full and entire amount of treatment given to me or to the above named patient at each visit. ***It is my choice to present my health insurance and pay according to my contract or to use the cash pay discount at the end of my visit.***

CONSENT FOR SERVICE &/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby consent to medical evaluations, testing and/or treatment provided to me by the staff of Urgent Care Hawaii, LLC. I also understand Urgent Care Hawaii, LLC, may use or disclose any Protected Health Information (PHI) necessary to carry out treatment, payment or healthcare operations. I authorize release of any information concerning me (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits. Otherwise payable to me, directly to the doctor and agree to pay any remaining balance once my Insurance Plan has processed my claim.

Signature of Patient or Guardian **Date**