St. Joseph's/Candler Immediate Care | South Georgia Immediate Care Center

YOUR IMMEDIATE CARE CENTERS™ *from* GEORGIA EMERGENCY ASSOCIATES

PATIENT REGISTRATION

Please present your insurance card(s) at the time of check-in.
Settlement of patient responsibility is expected at the time of service.

PATIENT INFORMATION

Last Name	First Name	MI
SSN	DOB	Gender ☐ M ☐ F
Street		Apt#/Lot#
City	State	Zip
Home Phone	Cell Phone	
E-Mail		
Best Form of Contact ☐ Home Phone ☐ Mobile Phone ☐ E-Mail	Leave Message? ☐ Y ☐ N	
Primary Care Physician*:		
** Information concerning your care provided by this center will be forwarded to your referring doctor unless otherwise specified.*		
Preferred Language	Race ☐ American Indian/Alaska Nat. ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Isl. ☐ White	Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Marital Status ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed		
Mailing Address if Different from Above:		
What is the reason for your visit today? (What are your Symptoms?)		
IF INJURY: Were you injured on the job? ☐ Y ☐ N	*Injury date:*	*Injury time:*

EMERGENCY CONTACT

Contact Name	Relationship	
Street		
City	State	ZIP
Home Phone	Cell Phone	

GUARANTOR (RESPONSIBLE PARTY IF PATIENT IS UNDER 18)

Name	Relationship	
DOB	SSN	
Street		
City	State	Zip
Home Phone	Cell Phone	

EMPLOYMENT

Employer		
Street		
City	State	Zip
Occupation	Title	
Employer Phone	Employee Phone	Employee E-mail

HOW DID YOU HEAR ABOUT US?

INSURANCE INFORMATION			
Is the patient covered by insurance? ☐ Y ☐ N			
PRIMARY INSURANCE		**SECONDARY INSURANCE**	
Insurance Co		Insurance Co	
Plan Name		Plan Name	
ID #		ID #	
Group #		Group #	
Insured Name		Insured Name	
Insured SSN		Insured SSN	
Patient's Relation to Insured ☐ Self ☐ Spouse ☐ Dependent ☐ Other		Patient's Relation to Insured ☐ Self ☐ Spouse ☐ Dependent ☐ Other	
Street		Street	
City		City	
State	ZIP	State	Zip
Mobile Phone		Mobile Phone	
Home Phone		Home Phone	
DOB		DOB	
Employer		Employer	
Copay Amount		Copay Amount	

Guarantee of Payment [SELECT ONE AND INITIAL]

SELF-PAY _____ (Initial)

I elect to pay in full for all services rendered today. I understand that my insurance will NOT be billed by Georgia Emergency Associates.

INSURANCE – ASSIGNMENT OF BENEFITS _____ (Initial)

I authorize payment directly to Georgia Emergency Associates for all benefits otherwise payable to me. I understand that I am financially responsible for all charges not covered by insurance. I authorize Georgia Emergency Associates to submit claims to my insurance carrier as well as medical records required to evaluate these claims for payment. I understand that if my employer is responsible for all or part of this claim, they will receive the necessary medical information required to evaluate these claims for payment.

Signature of Patient/Parent or Guardian	Date

AUTHORIZATION AND RELEASE

By signing below I acknowledge that I have read, understood and voluntarily consent and authorize the following:

Authorization of Treatment

I authorize the administration and cost of all medical and surgical procedures, x-rays and medication for myself and/or dependents.

Receipt of Privacy Practices

By signing this form, I acknowledge that I have received a Notice of Privacy Practices from Georgia Emergency Associates.

Release of Medical Records

I authorize Georgia Emergency Associates to release verbally, electronically and/or in writing confidential medical information obtained during the course of my examination and/or treatment to any person or entity, including my insurance carrier, employer (if treatment is related to employment) and/or other healthcare provider(s) for purposes of treatment, payment of charges, quality assurance and utilization review. I understand that should I choose not to release my medical records to a specific entity and/or person, I must specifically state so in writing for inclusion in my medical record.

Express Consent for Communication

By signing this form, I expressly consent and authorize St. Joseph's/Candler Immediate Care/South Georgia Immediate Care, its affiliates and agents, including any collection agency or debt collector hired by them, to communicate with me for any reason related to the services provided by St. Joseph's/Candler Immediate Care/South Georgia Immediate Care, including collection of amounts owed for said services. This communication may be made using an automatic telephone system or an artificial or prerecorded voice to the telephone number(s) I provide to St. Joseph's/Candler Immediate Care/South Georgia Immediate Care, its affiliates and agents as well as any telephone number assigned to a paging service, cellular telephone service, specialized mobile radio service or other radio common carrier service, or any service for which I am charged for the call. In addition, I further expressly consent and authorize St. Joseph's/Candler Immediate Care/South Georgia Immediate Care and its affiliates and agents, including collection agencies or debt collectors hired by them to communicate with me at any phone number, email address or other unique electronic identifier or mode St. Joseph's/Candler Immediate Care/South Georgia Immediate Care finds or obtains on its own which is not provided by me.

Visit Follow-up Communication

TEXT MESSAGE AND INFORMED CONSENT: In order to enhance patients' care and experience, St. Joseph's/Candler Immediate Care/South Georgia Immediate Care may contact you after your visit in order to request feedback on your experience by phone call, SMS text message, e-mail, voicemail, or mobile application, some of which may be via automated means. By signing below you understand and agree to be contacted in this manner with communications related to this visit, and any future visits. In the future, you may opt-out of receiving text messages by notifying us in writing (including responding via text message). Standard telephone minute and text charges may apply if we contact you. **MOBILE SAFETY TIPS:** While we work hard to protect your information, remember that electronic communication is never 100% secure. It's very unlikely, but information you send via text, email or mobile application, or that you leave on your mobile device, could be exposed to people other than your doctor. Here are a few safety tips to follow: (1) Use a password on your mobile device to prevent strangers from seeing what is on your phone. (2) Limit the amount of sensitive health information you send. You can always call your provider to discuss something private or sensitive. (3) If you are worried about those close to you seeing your messages, you can delete them from your email or messaging app. This won't erase them completely, but will make it hard for others to see them.

Signature of Patient/Parent or Guardian	Date

MEDICATIONS

Patient Name	Patient DOB	Today's Date

Please list all medications that you are currently taking

MEDICATION NAME	DOSAGE \ DIRECTIONS