Champlain Medical Urgent Care

New Patient Welcome Sheet

How did you hear about Champlain Medical Urgent Care:

☐ Friend ☐ Drive By ☐ Google ☐ Yelp ☐ Employer ☐ Insurance ☐Other: _____________

Why are you here today?

☐ Urgent Care ☐ PCP ☐ Work Injury ☐ Work Surveillance ☐ Drug Screen ☐ Pre-employment ☐Other: _________

Chief Complaint (please describe in your words your symptoms or injury) ______________________________________
____

If work injury, please note date of injury: _____________

Patient Information:

First Name: __________________________ MI _____ Last Name:____

Address: ____________________________________ City:______________________ State: _________ Zip:_______

Phone: __________________ Cell # (if different) __________________ Email: ______________________________

Date of Birth: __________________ Gender: M F U

How do you plan to pay for your services today?

☐ Self-Pay ☐ Bill my insurance which is: _______________________ and my ID is _________________________

And the subscriber for the policy is _______________________ and they are related to you as a

☐ self ☐ spouse ☐ parent ☐ other

☐ I was hurt at work and my Employer is ____________________________ and the contact for further information regarding my claim would be ________________________________ and their phone number is _______________

☐ My employer or potential employer has sent me here for these services

Assignment of Benefits – Financial Agreement:

I hereby authorize this office and its staff and practitioner to examine and treat my condition as the practitioner deem appropriate and I give authority for these procedures to be performed. I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment of services by this office. You are required to leave a credit/debit card on file that will be charged only after submission to your insurance carrier if applicable. Should collection of past due amount become necessary I will become responsible for all charges, fees and attorney fees. I (we) hereby authorize the practitioner to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Patient/Guardian _______________________________________ Date: __________________

Consent to Treat a Minor:

I (we) being the parents, guardian or custodian of the minor being: ____________________________________ do hereby authorize, request and direct this office, its practitioners and staff to perform examinations, and any treatment that in their judgement is deemed advisable or is required while said minor child is under care of this office's doctors and staff until legal age. All charges for service and care given to said minor child will be charged directly to me (us) and I (we) will personally be responsible for payment of them. I (we) hereby authorize the practitioner to release all information necessary to secure payments of benefits. I authorize the use of this signature on all insurance submissions.

Parent, Guardian, or Custodian Signature: ____ Date: ___________________________

Relationship to Patient: ____ Witness: _____________________ Date: ___________________________