HighDesertClinic
URGENT AND OCCUPATIONAL CARE

PATIENT REGISTRATION FORM

(Please Print Clearly and Complete Entire Form)

Patient Name:		Date of Birth:
Social Security Number:		☐ Male ☐ Female
Street/Mailing Address:		
City:	State:	Zip:
Main Phone Number:	Alternate Phone Number:	
Email Address:	☐ Single ☐ Married ☐ Widowed ☐ Divorced	
☐ Hispanic ☐ Black ☐ White ☐ Asian ☐ American Indian ☐ Pacific Islander ☐ Other	Preferred Language:	
Reason for today's visit: Preferred Pharmacy:		
Emergency Contact:	Phone Number:	
How you heard about us: ☐ Friend ☐ Relative ☐ Work	☐ Newspaper ☐ Phonebook ☐ Radio ☐ TV	☐ Doctor Referral ☐ Internet ☐ School ☐ Other
Employer Name:		
Address:	Phone Number:	

Responsible Party (**Policy Holder** of Insurance AND/OR **Guarantor** if Patient is Under 18)

Name:	Relationship:
Date of Birth:	Social Security Number:
Address:	Phone Number:
Employer:	

Insurance Information (**Please Give All Insurance Cards to the Receptionist for Scanning**)

Primary Insurance:	ID number:
Secondary Insurance:	ID Number:

Acknowledgement of Patient Rights (laminated page on clipboard)

_____ _____
Signature of Patient (**OR** Guardian **if** patient is under 18) Date

Acknowledgement of HIPAA (laminated page on clipboard)

_____ _____
Signature of Patient (**OR** Guardian **if** patient is under 18) Date

***If you would like a copy of your Patient Rights or HIPAA, please ask the front desk.**

HighDesertClinic
URGENT AND OCCUPATIONAL CARE

PATIENT FINANCIAL RESPONSIBILITY

High Desert Clinic accepts many insurance plans; however, it is my responsibility to ensure my benefit eligibility, as benefit options vary, prior to seeking care at High Desert Clinic.

I hereby authorize and direct payment of my medical benefits to High Desert Clinic on my behalf for any services furnished to me by the providers.

I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered services. Co-payments are due at time of service. If my plan requires a referral, I must obtain it prior to my visit. In the event that my health plan determines a service to be "not payable," I will be responsible for the complete charge and agree to pay the costs of all services provided. If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

I will be responsible for any additional expenses High Desert Clinic may incur in the collection of an outstanding balance on my account. If it becomes necessary to forward my account to a collection agency, an additional 35% fee will be added to my balance and High Desert Clinic will refuse service until balance is paid in full. Additionally, High Desert Clinic's affiliates may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers which could result in charges to me.

High Desert Clinic is unable to accept checks at this facility. If I submit payment to High Desert Clinic's billing office by check and it is returned for insufficient funds, there will be an additional $25.00 fee. High Desert Clinic will also charge a $25.00 fee for any disputed valid credit card transaction.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form.

_____ _____
Signature of Patient (**OR** Guardian **if** patient is under 18) Date

---

GENERAL CONSENT FOR CARE AND TREATMENT

T*O THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended medical treatment, operation or procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate medical treatment, operation or procedure for any identified condition(s).*

This consent provides High Desert Clinic with my permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, I am indicating that (1) I consent to treatment at High Desert Clinic and (2) I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain fully effective until it is revoked in writing. I have the right at any time to discontinue services.

I have the right to discuss the treatment plan with my provider about the purpose, potential benefits and risks of any test ordered for me. If I have any concerns regarding any test or treatment recommended by my provider, High Desert Clinic encourages me to ask questions.

I voluntarily request that a provider, nurse, medical assistant or radiology technician perform reasonable and necessary medical examinations, tests and treatments for the condition which has brought me to seek care at High Desert Clinic. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____
Print Name of Patient (**OR** Guardian **if** patient is under 18) Relationship to Patient

_____ _____
Signature of Patient (**OR** Guardian **if** patient is under 18) Date

_____ _____
Printed Name of Witness Signature of Witness Date