



Utica Park Clinic

A Service of Hillcrest HealthCare System

NEW PATIENT REGISTRATION
UPC0026 (REV. 10/07)

		MRN:	
		PCP:	
PATIENT			
Legal name: Last, First, Middle		Also known as:	
Social Security #	Date of Birth / /	Sex: M F	Marital status: M S W D
Address	City	State	Zip
Home phone (with area code)	Cell phone (with area code)		
E-mail Address			
Employer	City	State	Zip
Work phone (with area code)			
Responsible party/Legal guardian			
Guarantor name		Relationship to Patient	
Date of Birth / /	Social Security #		
Address (if different than patient)	City	State	Zip
Home phone (with area code)	Cell phone (with area code)		
Employer	City	State	Zip
Work phone (with area code)			
Emergency contact #1 Nearest relative or friend not living with you.			
Name		Relationship to Patient	
Address	City	State	Zip
Home phone (with area code)	Work phone (with area code)		
Employer			
Emergency contact #2 Nearest relative or friend not living with you.			
Name		Relationship to Patient	
Address	City	State	Zip
Home phone (with area code)	Work phone (with area code)		
Employer			
Insurance			
Is today's visit due to an accident? YES NO	If yes, date of injury / /	If yes, what type of injury? (circle one) Work Motor Vehicle Personal Injury Other	
Insurance company name			
Address	City	State	Zip
Phone (with area code)	Contact:		
Policy #	Claim #		
Pediatrics only; Please list brothers and/or sisters			
Name	Date of Birth / /		
	/ /		
	/ /		

PATIENT AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

AUTHORIZATION FOR TREATMENT. By virtue of my signature, I authorize UPC, and any of its employees or other authorized personnel or agents, to provide general healthcare services to me.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION. I hereby authorize UPC, and any of its employees or other authorized personnel or agents, to release any of medical records or other personal or medical information for purposes of determining benefits for services; for purposes of obtaining reimbursement from my insurance company of record, any public agency or any other potential third party payer. I further authorize UPC, and any of its employees or other authorized personnel or agents, including any laboratory or diagnostic testing facility performing services on my behalf, to release any of my medical records or other personal or medical information to any employee, authorized personnel or other agent of any physician, laboratory or diagnostic testing facility, or other healthcare provider involved in my care or treatment, for purposes of billing or obtaining reimbursement from any payer, for the purpose of developing an appropriate treatment plan or diagnosis, or for purposes of quality assurance, utilization review or other analyses designed to monitor and maintain a quality of care. **IN AUTHORIZING THIS RELEASE OF INFORMATION, I HAVE READ THE NOTICE TO PATIENTS SET FORTH BELOW AND I UNDERSTAND THAT SUCH INFORMATION MAY INDICATE THAT I HAVE OR MAY HAVE A COMMUNICABLE OR VENEREAL DISEASE, INCLUDING BUT NOT LIMITED TO DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND THE HUMAN IMMUNODEFICIENCY VIRUS (ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME OR AIDS)**

NOTICE TO PATIENTS: Any information in your medical record which indicates that you have or may have a communicable or venereal disease, including, but not limited to any of the diseases listed above, is deemed confidential information pursuant to Section 1052.2 of Title 63 of the Oklahoma Statutes. According to that law, your confidential information cannot be released without your express permission, except in very limited circumstances. Release of such confidential information may be allowed to persons who have been exposed to the risk of infection, pursuant to an order of the court or pursuant to an order of the State Department of Health, or among health care providers or agencies for statistical or epidemiological purposes. Even in these circumstances, release may only be allowed if the release can be made without any identifying information.

FINANCIAL STATEMENT. Payment is due immediately upon the provision of services unless a previous arrangement has been made. New patients are required to pay total charges, the full amount of their co-payment, or a minimum of 20% at the time if UPC files the claim for benefits with the primary insurance company. Failure to pay the co-payment at the time of service can result in loss of healthcare benefits and/or dismissal from UPC. I understand that if I am unwilling to authorize UPC to release information for purposes of obtaining reimbursement or determining coverage may result in UPC requiring me to pay in full on a cash basis at the time services are rendered. I understand that I am financially responsible to UPC for any charges that are not covered by my insurance company or any other third party payers, and I agree to be bound by UPC's payment policies, as articulated above. Any patient having an outstanding balance on their account which is unpaid for 90 days or more will be required to pay for any charges incurred at the time of service and to make arrangements for the payment of any outstanding balance due on the account. Any patient having an outstanding balance on their account that is unpaid for 120 days or more will have their account turned over for collection and any future services will be made available only on a immediate cash payment basis. UPC may, at its discretion, choose to work with those patients who incur accounts having a large dollar balance, by creating a payment schedule or other appropriate arrangement. In the event of my default I agree to pay all costs of collection incurred by UPC, including but not limited to my attorney's fees. By virtue of my signature below, I hereby acknowledge that I have read the above information and that I agree to be bound by all of UPC's payment policies.

ASSIGNMENT OF BENEFITS. I hereby authorize payment of any benefits for services rendered by UPC to be made directly to UPC. I authorize UPC to refund any overpaid insurance benefits where the overpayment is subject to coordination of benefits.

PATIENT ACKNOWLEDGEMENT. By virtue of my signature below, I hereby acknowledge that I have read and understand all of the above, and that I have been given adequate opportunity to ask any questions about the same.

SIGNATURE. By Patient's signature below, Patient represents that Patient is 18 years of age or over and is legally capacitated to give consent to treatment and to authorize release of the above information. By signature of a Parent or Legal Guardian below, such individual represents that Patient is under age 18 (a minor) or has a court-appointed guardian.

Patient's Signature (Adult, capacitated) _____ Date _____ Time _____ PM / AM

Patient's Name Printed _____ Patient's D / O / B _____ Patient's SSN _____

Signature of Parent / Legal Guardian _____ Relationship to Patient _____ Date _____ Time _____ PM / AM