OneSource HEALTHCARE
URGENT CARE - FAMILY MEDICINE - CHIROPRACTIC

☐ Urgent Care Appointment Scheduled With

Date _____

No change in past year _____ Initials

☐ Dr. Troy Alderman, NP-C
☐ Dr. Donnie Butler
☐ Dr. Davis Kinney
☐ Dr. Dan Webb
☐ Dr. Chad Tuten
☐ Dr. Jorge Pisarello
☐ Cindy Caldwell, FNP-C
☐ Melanie Yawn, FNP-C
☐ April Heard, FNP-C
☐ Beth Hollis, FNP-C

Tell Us About You

Name _____ _____ / _____ / _____
First Middle Last Social Security Number

Name You Prefer To Be Called _____ Male ☐ Female ☐ Date of Birth _____

Race: Caucasian ☐ African American ☐ Asian ☐ Other Race ☐ Ethnicity: Hispanic ☐ Non-Hispanic ☐

Address _____ City _____ State _____ ZIP _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____ Marital Status: M ☐ S ☐ W ☐ D ☐

Employer _____ Not Employed ☐ Homemaker ☐ Retired ☐ Disabled ☐

Job Title _____ Work Address _____

Primary Care Physician _____ Permission to contact? _____

Who may we thank for referring you to our office? _____

Preferred Pharmacy _____ Phone _____

Emergency Contact

Name _____ Relationship _____ Phone _____

Designated person(s) we may discuss/release your medical information to: _____

Do you have an Advance Directive? If yes, who has been given legal right to make (near) end-of-life decisions for you? _____

Tell Us How You Will Pay

Please give insurance card to receptionist to make a copy.

Do you have health insurance? _____ Policy Holder Name _____

Policy Holder SSN _____ / _____ / _____ Policy Holder Date of Birth _____

Policy Holder Address _____ City _____ State _____ ZIP _____

Worker's Comp ☐ Injury Date _____ Reported at Work? _____ Authorized by/phone _____

Auto Accident ☐ Adjuster _____ Claim # _____ Attorney _____

AUTHORIZATION & RELEASE

By signing this consent form, I acknowledge that I have read, understand, voluntarily consent to and authorize the following:

Authorization of Treatment: The administration and cost of all medical and surgical procedures, x-ray and medication for myself and for my dependents.

Guarantee of Payment: INSURANCE Assignment of Benefits - I authorize payment directly to OneSource Healthcare Group, LLC (OneSource) for all benefits otherwise payable to me. I also acknowledge that OneSource will submit my bill to my insurance carrier as a courtesy; however, I am ultimately responsible for all charges incurred. I agree that I will pay my estimated balance today based on the best available information of my current policy and OneSource's current contract with my insurance carrier. I understand this is only an estimate and after my visit is processed with my insurance company, I will be billed for any outstanding balance and/or refunded for any credit due to or by me. While OneSource makes every effort to verify my correct insurance information prior to leaving, I understand OneSource cannot guarantee the accuracy of my bill until it has been fully processed by my insurance carrier and that I am ultimately responsible for all charges incurred.

Release of Medical Records: I authorize OneSource Healthcare Group, LLC to release and/or receive verbally, electronically, and/or in writing confidential medical information to any person or entity including my insurance carrier, employer (if treatment is related to employment), immediate family member(s), and/or other healthcare provider(s) for purposes of treatment, payment of charges, quality assurance and utilization review, transfer and follow-up procedures. I understand that should I choose not to release my medical record to a specific entity and/or person(s) I must specifically state so in writing to be kept in my medical record.

Receipt of Privacy Practices: By signing this consent form I acknowledge that a copy of the Notice of Privacy Practices of OneSource Healthcare Group, LLC is available to me upon request and can be downloaded at **www.onesource-healthcare.com.** I understand that a copy of this consent form may be used with the same effectiveness as the original.

FINANCIAL & PRIVACY POLICY

Thank you for choosing OneSource Healthcare as your health care provider. The following is an overview of our Financial Policy. If you have any questions or concerns about our payment policies please do not hesitate to ask our business office personnel. We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Forms prior to seeing the doctor.

The patient's portion of payment is due at the time services are rendered unless prior arrangements have been made with the business office manager. We accept assignment with most major insurance companies and participating provider plans. However, you must understand that:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance carrier.
2. All charges are your responsibility whether your insurance company pays or not.
3. Fees for services, along with unpaid deductibles and co-payments, are due at the time or treatment.
4. If the insurance company does not pay your balance in full within 30 days we ask that you contact the carrier to request prompt payment. Please inform our office of the carrier's response.
5. Returned checks will be subject to $30.00 collection charge. We will notify you by certified letter. If the check is not picked up within 10 days the check will be turned over to law enforcement.
6. Unpaid balances over 90 days are subject to collections via small claims court, attorney, and/or collection agency with applicable collection fees. Collection fees are the responsibility of the patient.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Authorization of Release and Assign Insurance Benefits: I authorize release of any information required to act on any insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to **OneSource Healthcare Group, LLC** the medical and/or surgical benefits I am entitled from my insurance company and/or Medicare.

This authorization is in effect for all future claims, until I choose to revoke it in writing.
I, the undersigned, understand and agree to the above Financial Policy. I understand that I am personally financially responsible for all charges incurred for my medical treatment and other services I receive from OneSource Healthcare Group, LLC's providers.

Patient Signature (or Authorized Signature) _____ Date _____

Printed Name of Patient _____ Relationship to Patient (if not patient) _____

Authorized Witness _____