MEDNOW

Urgent + Primary Care

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Tel (706)922-3669, Fax (706)364-7971

2851 Washington Road, Augusta, GA 30909
Tel (706)922-6578, Fax (706)922-6579

3044 Peach Orchard Road, Augusta, GA 30906
Tel (706)798-4673, Fax (706)798-7378

469 Lewiston Road, Grovetown, GA 30813
Tel (706)941-3333, Fax (706)941-3334

Thank you for choosing our office! In order to serve you properly, we need the following information:

Patient Information: Date: ____/____/_______

Patient:

Last Name: ______________________________ First Name: ____________________________ MI: _______

DOB: _____/_____/_____ Social Security Number: ________-________-_______

Address: ____ Apt #:_________

City: ______________________________ State: ________ Zip: ___________

Phone – (______) ______ - _______ Email Address: ____

Emergency Contact: ______________________________________ Phone: _____________________________

Relation: ____

Consent For Services:

The undersigned give consent for MedNow Urgent Care, LLC, its authorized representatives, its physician, providers, and/or Independent Physician Contractors to provide appropriate medical services including diagnostic and radiological procedures, administration of medicines and other treatment and care considered advisable or necessary by the patient's treating physicians and providers. The undersigned also gives consent for MEDNOW Urgent Care, LLC, to disclose to my employer, if applicable, the history, physical, lab results, and results of any drug/alcohol testing that may relate to my visit. I understand that these results may be used to determine my fitness for employment or continued employment with the company.

X_______________________________________ ____________________

Signature of Patient or Authorized Representative Date

Privacy Notice (HIPAA):

By signing below, I acknowledge that I have received/reviewed a copy of the Privacy Policy of MedNow Urgent Care, and I authorize MedNow Urgent Care to use and disclose my protected health information for the purposes of treatment, payment, and healthcare operations, as described in the Privacy Policy.

X_______________________________________ ____________________

Signature of Patient or Authorized Representative Date

Financial Policy:

By signing below, I acknowledge that I am receiving occupational services from MedNow Urgent Care which **will not** be billed to my insurance plan. I understand that payment is expected in full at the time services are rendered and **no refunds will be issued once exam/services have begun**. If the charges, that are my responsibility, are not paid within thirty (30) days of receipt of any bill, I agree to pay any additional expenses incurred due to the delinquent account, including collection agency fees, and/or reasonable attorney fees if applicable, if the account is placed for collection. All returned checks incur a $35.00 service charge or the maximum allowed by law, to be paid by cash or credit card along with balance of the patient's account within 10 days of notification by MedNow or its assigned agent. Failure to comply and meet financial responsibility may also result in a patient discharge from practice.

X_______________________________________ ____________________

Signature of Patient or Authorized Representative Date