



PLEASE COMPLETE THE FOLLOWING INFORMATION  
(PLEASE PRINT CLEARLY AND LEGIBLY)

DATE: \_\_\_\_\_

REASON FOR VISIT: \_\_\_\_\_

**PATIENT INFORMATION:**

PATIENT LAST NAME: \_\_\_\_\_ FIRST: \_\_\_\_\_ MI: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT #: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME #: (\_\_\_\_) \_\_\_\_\_ CELL #: (\_\_\_\_) \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_-\_\_\_\_-\_\_\_\_ SEX:  M  F DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_

PARENT/GUARDIAN (if patient is a minor): \_\_\_\_\_

ADDRESS (if different from minor): \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME #: (\_\_\_\_) \_\_\_\_\_ CELL #: (\_\_\_\_) \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_

HOME #: (\_\_\_\_) \_\_\_\_\_ CELL #: (\_\_\_\_) \_\_\_\_\_

IN THE EVENT OF AN EMERGENCY, DO WE HAVE YOUR PERMISSION TO SHARE HEALTH-RELATED INFORMATION WITH THE PERSON LISTED ABOVE?  YES  NO

**INSURANCE INFORMATION:**

PLEASE PRESENT YOUR INSURANCE CARD AND PHOTO ID TO THE REGISTRATION STAFF. OUR STAFF WILL MAKE A COPY FOR OUR RECORDS.

NAME OF INSURANCE COMPANY: \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ DATE OF BIRTH OF INSURED \_\_\_\_/\_\_\_\_/\_\_\_\_

ID# / POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_

**For Office Use Only**

Date of Last Visit: \_\_\_\_\_

Copy of Insurance Card:  Yes

Copy of ID:  Yes



We are providing you with this information so that you are fully informed of our payment policies.

**Patients with Insurance:**

- We will file your claim directly to your insurance company. However, if this claim is denied, you will be fully responsible for payment to include any additional costs associated with enforcing this agreement, collection costs and reasonable attorney’s fees.
- We expect that your insurance company may not pay for routine services such as flu shots, immunizations, physicals, dental ailments and other services not related to an acute illness or injury.
- We will collect a co-pay of \$25.00 (unless otherwise stated on your insurance card) at the time of registration.

**Assignment of Benefits**

- I hereby assign all medical benefits to which I am entitled to Inova Urgent Care Center. This applies to all insurance carriers, including Medicare, private insurance, and any other health / medical plan.
- I understand that it is my responsibility to report any changes to insurance coverage.
- I authorize the release of any medical or pertinent information necessary to obtain these benefits to my insurance carrier, or any other medical entity for continued medical care.
- I understand that I am financially responsible for any amount not covered by my insurance plan.

**Self-pay Patients:**

- a fee of \$193.00 will be collected from new patients at the time of check-in
- a fee of \$187.00 will be collected from established patients at the time of check-in. (Established patients are those who have been treated at an Inova Urgent Care Center within 3 years from today’s date).

The Registration Staff will verify your status prior to collecting your payment.

Any additional charges that are incurred during your visit will be collected prior to your leaving the facility or billed to you directly.

\_\_\_\_\_  
Patient / Guarantor Signature

\_\_\_\_\_  
Date

**THANK YOU FOR CHOOSING AN INOVA URGENT CARE CENTER!**