# JUFC REGISTRATION FORM – PLEASE PRINT LEGIBLY

## PATIENT INFORMATION

| | | |
|---|---|---|
| Last Name: | First Name: | MI: |
| Preferred Name (Nickname): | Date of Birth (DOB): | SSN: |
| Gender: ☐ Male ☐ Female | Email Address: | |
| Mailing Address: | | |
| City: | State: | Zip Code: |
| Home Phone: ☐ Preferred | Primary Care Provider: ☐ None | |
| Work Phone: ☐ Preferred | Referring Provider: | |
| Cell Phone: ☐ Preferred | Marital Status: | |
| Are you currently employed? ☐ No ☐ Yes – Where: | Position: | |
| Are you looking to transfer care from another provider? ☐ YES ☐ NO Name of Provider: | | |
| Emergency Contact (EC): | Relationship: | |
| EC Home Phone: | EC Cell Phone: | EC Work Phone: |
| Financially Responsible Party / Guarantor: | SSN: | |
| Date of Birth: | Relationship to Patient: | |

## METHOD OF PAYMENT

(Please present your Photo ID and Insurance Card to the front desk)

| | | |
|---|---|---|
| Are you insured? ☐ Yes ☐ No | Are you uninsured or otherwise self-pay? ☐ Yes ☐ No | |
| Insured/Policy Holder: | DOB: | Relationship: |
| Insured/Policy Holder: | DOB: | Relationship: |
| If you have Tricare, please indicate your sponsor's SSN or DOD#: | | |

## DEMOGRAPHICS

| | | |
|---|---|---|
| OK to leave messages **at home:** ☐ Yes ☐ No | OK to leave messages **on cell:** ☐ Yes ☐ No | OK to leave messages **at work:** ☐ Yes ☐ No |
| Race: ☐ American Native / Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Hispanic ☐ White / Caucasian ☐ Other: ☐ I Decline | | |
| Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown ☐ I Decline | Primary / Preferred Language: ☐ English ☐ Spanish ☐ Tagalog ☐ Other (specify): | |
| Preferred Communication: ☐ Email ☐ Home Phone ☐ Cell Phone ☐ Mail | Do you require translation? ☐ Yes ☐ No | |
| How did you hear about our clinic? ☐ Word of Mouth ☐ Saw Sign on Building ☐ Employer ☐ Was a Patient Long Ago ☐ Internet ☐ Physician/Other Referral ☐ Relative ☐ Other: | | |

My signature below specifies that, to the best of my knowledge, the information provided is accurate and up-to-date. I acknowledge that incorrect information may result in billing errors and possible balance turnover to me.

_____

Patient or Legally Authorized Representative / Guarantor Signature Date

## OUR FINANCIAL POLICY

Juneau Urgent & Family Care (JUFC) is dedicated to providing the best possible care for you, and we want you to completely understand our financial policies:

1. Payment is due at the time of service unless other arrangements have been made in advance by your insurance carrier, our front desk staff, or our billers. We accept cash, checks, debit cards and the four major credit cards.
2. It is always the patient's responsibility to keep us up-to-date with all changes to demographics and/or insurance policies to be able to correctly facilitate proper billing practices. Incorrect information may result in balances being transferred to a patient's responsibility.
3. There is a $35.00 returned check fee for all returned checks. After the first returned check we will only accept cash or credit cards until further notice.
4. Many insurance policies require co-pay at the time of service. You are ultimately responsible for the complete balance due of each visit. As a courtesy to you, we will bill your insurance company for the claim. If your carrier does not pay the claim within a reasonable period (60 days from submission date), the balance from the office visit becomes your responsibility and we will look to you for payment. If we receive a check from your carrier after you have paid, we will refund any overpayment to you.
5. It is possible that your insurance company will occasionally group charges together and consider them "bundled fees". If these are not found to comply with proper coding, we will not accept this processing of claims and will forward the balance due to you.
6. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "non-covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
7. You will be responsible for the difference between our charges and the amount paid by your insurance.
8. Patients with a balance over 90 days will be sent to collections with interest at .88% per month added to the principal balance, not to exceed 10.5% per year.
9. Please be aware of an additional fee of $149.50 for emergency care provided that interrupts the queued flow of business.
10. JUFC follows a 24-hour cancellation policy for appointments. Cancellation of an appointment must be made at least the day before your appointment time. Failure to do so will result in a $25.00 missed appointment fee after a one-time warning. If we're your Primary Care Provider and you miss 3 appointments we will no longer be considered your Primary Care Provider.
11. If you have not been a patient at JUFC within the last three years you will be considered a new patient.
12. Our clinicians are focused on optimal patient care and will not have prices readily available. Please see the front desk prior to services being rendered if there is a concern for cost.
13. Please be aware that First Data, our credit card processor, is the only party allowed to view any credit card information you allow JUFC to use. Neither JUFC nor our practice management software accesses this information.

## HIPAA ACKNOWLEDGEMENT AND AUTHORIZATION

The JUFC Privacy Policy Notice lists at length ways in which the practice may use and disclose your Personal Health Information. This Notice is available publicly, included with the initial registration forms, and can be provided to you at any time should you request a copy. Please review it carefully. We would also like to express that a chaperone is available upon request

If you would like to allow us the ability to send you information by type via email and/or voicemail, please select an option below. Likewise, if you would like to allow any specified persons access to your account, please indicate. If you choose to opt out, please leave these blank.

___Appointments ___Release of Medical Records ___Medically Critical Information
___Lab Results ___Radiology / Diagnostic Imaging Results
___Other_____

| NAME (IF NOT SELF) | EMAIL | NUMBER TO LEAVE VOICEMAIL |
|---|---|---|
| | | |
| | | |
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_____ **(Signature)** **Prior Authorization Policy** - Juneau Urgent and Family Care does not perform insurance prior authorizations for medications. It is up to you to contact your insurance and find the medications your insurance will pay for without prior authorization. Once you obtain the name of the medication that does not require prior authorization, our providers will change the prescription to that medication.

You expressly consent and agree that, in order to discuss or service your accounts(s) (the "Accounts ") or to collect amounts you may owe, Juneau Urgent & Family Care, and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively, "We") may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contact you by sending text messages, emails, using any e-mail address you provide to us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

I have read and understand the practice's financial and prior authorization policies and I agree to be bound by their terms. I also understand and agree that such terms may be amended by the practice from time to time. This policy also supersedes any previous policy I may have signed with JUFC. By signing below, I indicate that I acknowledge and understand the rights available to me as per HIPAA, and allow JUFC to facilitate healthcare operations, and/or in an expedited manner if I have indicated alternate means of communication. You may use or disclose my personal health information with other healthcare professionals for the purpose of care continuity.

My signature below specifies that, to the best of my knowledge, the information provided is accurate and up-to-date. I acknowledge that incorrect information may result in billing errors and possible balance turnover to me.

_____ _____
Patient's Name (Please Print) Date of Birth

_____ _____ _____
Signature of Patient or Legally Responsible Party Relationship to Patient Today's Date