Patient Information

Date: _____

First Name _____MI _____ Last Name _____ Date of Birth _____
Sex _____ Circle Race: American Indian / Asian / African American / Hispanic / White
Ethnicity (circle one) Hispanic or Latino / Not Hispanic or Latino Social Security # _____ - ____ - _____
Address _____
City _____ State _____ Zip _____ Marital Status _____

Employment Information

Employment Status (circle one) Employed / Unemployed / Full Time Student / Part Time Student / Other
Employer Name _____ Employer Phone_____
Employer Address _____
Employer City _____ Employer State _____ Employer Zip _____

Patient Contact Information

Home Phone _____ Work Phone _____ Ext _____ Cell Phone _____
Email Address _____ Written Contact Preference (circle one) Postal Mail / Email

Emergency Contact Information

Emergency Contact Name_____
Phone _____Relationship _____
Address _____
City_____ State_____ Zip_____

Insurance Policy Holder

Relationship to Patient (circle one) Self / Spouse / Child / Other
First Name _____MI _____ Last Name _____
Date of Birth _____ Sex _____
Address _____
City _____ State _____ Zip _____ Phone _____
Primary Insurance _____ Policy # _____ Group # _____
Secondary Insurance _____ Policy # _____ Group # _____

Guarantor Information

Relationship (circle one) Self / Primary Insured/ Other _____

Note: Any person under 18, the Guarantor is the parent/guardian of the child that is bringing the child in for treatment. Any person over 18 years of age is their own guarantor

First Name _____MI _____ Last Name _____ Date of Birth _____
Sex _____ Race (circle one) White / African American / American Indian / Hispanic / Other
Ethnicity (circle one) Hispanic or Latino / Not Hispanic or Latino Social Security # _____ - ____ - _____
Address _____
City _____ State _____ Zip _____ Marital Status _____
Employment Status (circle one) Employed / Unemployed / Full Time Student / Part Time Student / Other
Employer Name _____ Employer Phone_____
Employer Address _____
Employer City _____Employer State _____ Employer Zip _____
Guarantor Contact Information
Home Phone _____ Work Phone _____ Ext _____ Cell Phone _____
Email Address _____

Please read and sign on back

Insurance release: I authorize release of all medical information pertaining to services rendered by ExpressCare Plus, including, but not limited to: billing information, utilization review, quality assurance, referral to specialist, HIV/HBV testing, drug/alcohol abuse, psychological/psychiatric conditions, STD, and birth control. This will include both the mailing and faxing of records. All insurance benefits for said services may be paid to ExpressCare Plus. I am responsible for insurances' contractual non-covered services, which includes services that my insurance may deem medically unnecessary, copays and deductibles. Should the account go to a collection agency, any reasonable attorney fees and court cost will be my responsibility. This release will expire in one year unless revoked in writing.

We thank you for choosing ExpressCare Plus to provide your medical care. We look forward to building a long relationship with you and your family members. As your doctors, we are committed to providing you with the best possible medical care. To assist us with this effort, please communicate your needs to us at each visit. We will make every effort to assist you.

ExpressCare Plus provides both scheduled appointments and "walk in" services.

- Scheduled appointments for routine physical or pap examinations are available.
- "Walk in" service is available for minor acute medical problems that cannot wait for a scheduled appointment time.

ExpressCare Plus is open every day except Christmas Day.

- Weekday hours are 8:00 a.m. to 7:00 p.m.
- Weekend and holiday hours are 9:00 a.m. to 4:00 p.m.
- We appreciate a 24-hour notice of cancellation of scheduled appointments.

ExpressCare Plus' policy is that our fees must be paid in full at the time of service.

- If you are a cash paying patient, ExpressCare Plus offers a discount on selected office charges, not to include copays, co-insurance or deductibles.
- **Your insurance identification card must be presented at each office visit**.
- We do not accept assignment on Medicare. All Medicare patients are required to pay the Medicare limiting prices at the time of service. We submit the claims to Medicare and Medicare will reimburse you.
- ExpressCare Plus is NOT contracted with Medicaid. I understand that if I have Medicaid as my primary insurance, I will be responsible for the payment in full at the time of service. If Medicaid is my secondary insurance, I can be billed for any unpaid balance that my primary insurance does not cover.
- If we are not contracted with your insurance plan, full payment is required at the time of service.
- If we are contracted with your insurance plan, you must pay your deductible or co-payment or co-insurance amount before you see the doctor.
- Insurance is not a substitute for or an acceptable reason to delay your responsibility to pay your account in full.
- If you have questions about your insurance coverage, we will do our best to be of help, but it is your responsibility to contact your insurance carrier.
- If payment on an account is not received within 60 days a late fee of $15.00 will be assessed.
- A $25.00 fee will be charged for all returned checks.

Please notify our receptionist at the time you register if any information regarding your address, telephone number or insurance coverage has changed since your last visit.

Again, welcome, and thank you for choosing ExpressCare Plus.

By signing this from, I am agreeing to and understanding all ExpressCare Plus' policy listed on this form.

Signature _____ Date _____