COMPLETE EMERGENCY CARE

Established Patient

PATIENT INFORMATION

Last Name _____ First Name _____ Date of Birth: _____

PARENT/GUARANTOR INFORMATION

Last Name _____ First Name _____ Middle _____

Date of Birth _____ /_____ /_____ Age _____ Sex ☐M ☐ F Email_____

Address _____ APT #_____ City _____ State _____ Zip _____

Cell Phone (_____) _____ - _____ Home Phone (_____) _____ - _____

Employer _____ Work Phone (_____) _____ - _____

Emergency Contact Name_____ Relationship _____ Phone (_____) _____ - _____

PRIMARY INSURANCE

Carrier _____

Member ID_____Group # _____

Phone _____

Policy Holder Name _____

Date of Birth_____/_____/_____ Sex ☐M ☐ F

Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian ☐ Spouse

SECONDARY INSURANCE

Carrier _____

Member ID_____Group # _____

Phone _____

Policy Holder Name _____

Date of Birth _____/_____/_____ Sex ☐M ☐ F

Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian ☐ Spouse

PRIVACY PRACTICES & PATIENT RIGHTS

By signing this form, I acknowledge that a copy of the Notice of Privacy Practices of Complete Emergency Care is available to me upon request and can be downloaded at www.completeemergencycare.com. Further, I acknowledge that I have been provided with a copy for review and/or take home of "Patient Rights and Responsibilities".

ANCILLARY SERVICE

___ **Initial**: Your ER Physician may recommend certain laboratory and/or radiology tests to help aid in the treatment and diagnosis of your condition. . Some of these tests are not routinely performed in our facility. Your laboratory test may be sent to one of the following independent laboratories; _____ or _____. Should an x-ray or CT be required, the test will be performed here and an independent radiologist will read and interpret the x-ray or CT and provide a report on their findings. _____ Radiology is an independent company and you will be billed separately for these interpretation charges only. **You may receive a separate bill for services provided by an outside lab and/or radiology reading. This is not a bill from Complete Care. Complete Emergency Care is not responsible for these charges.**

AUTHORIZATIONS AND CONSENT TO TREAT

Authorization of Treatment: By signing this consent form, I voluntarily consent to the administration, treatment and cost of surgical procedures, radiology procedures, medication and other ancillary medical services for myself or my dependent. I understand that a copy of this consent form may be used with the same effectiveness as the original.

_____Initial: I understand this is an emergency facility and is billed as an emergency room visit including a facility fee to my insurance.

Guarantee of Payment: If insurance is filed on my behalf for charges associated with care provided by Complete Emergency Care and the company's assigned physician group, **I assign to the provider all payments from insurance companies or third party payors**. CEC may use and disclose my healthcare information to an insurance company or third party payor for the purposes of payment if a claim is filed on my behalf. I acknowledge that if CEC submits a claim to my insurance carrier, it is done so as a courtesy and that I am ultimately responsible for all charges incurred, unless both parties mutually agree otherwise. I agree that I will pay my estimated out of pocket based on the best available information of my current policy and understand this is only an estimate. While CEC makes every effort to verify my correct insurance information, I understand CEC cannot guarantee the accuracy of my bill until it has been fully processed by my insurance carrier. **If insurance will not be filed on my behalf, I agree to pay for all services rendered in full at the time of the visit.** By electing to be self-pay, I understand that any insurance that may be in effect at the time of service will not be billed by CEC and I will receive a global non-itemized receipt. An itemized receipt will not be available at the time of service or anytime in the future. I understand that if paying by check and it is returned, a processing fee of $30 will be assessed. I attest that the information provided to CEC and written herein is true and accurate.

Signature: _____ Date:_____

**All references to Complete Emergency Care (CEC) include the company's physician group CEC ER Physicians PLLC.*