STATMED QUICK QUALITY URGENT CARE
REGISTRATION FORM

(Please Print)

Today's date:			Primary Care Dr.:			
PATIENT INFORMATION						
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	(Former Name)	Social Security no.:	Birth date: / /	Age:	Sex: ❑ M ❑ F	Race:
Street address:					Home phone #: ( )	
P.O. box:	City:	State:	ZIP Code:		Employer phone #: ( )	
Occupation:	Employer:				Cell phone #: ( )	
Pharmacy: Address or Intersection:		Phone:				
Chose clinic because/Referred to clinic by (please check one):		❑ Dr.	❑ Billboard	❑ TV Commercial	❑ Internet	
❑ Family/Friend	❑ Close to home/work	❑ Yellow Pages	❑ Advertisement Where?	Other		
Other family members seen here:			**Email:**			
INSURANCE INFORMATION						
(Please give your insurance card and Driver's License to the receptionist)						
Person responsible for bill:	Birth date: / /	Address (if different):		Home phone no.: ( )		
Is this person a patient here? ❑ Yes ❑ No						
Occupation:	Employer:	Employer address:		Employer phone no.: ( )		
Is this patient covered by insurance? ❑ Yes ❑ No						
Please indicate primary insurance	❑ United Healthcare	❑ Aetna	❑ Blue Cross Blue Shield	❑ Humana	❑ Medicare	
❑ Cigna	❑ Great West	❑ AvMed	❑ Tricare	❑ Other		
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		
Name of secondary insurance (if applicable):	Subscriber's name:		Birth date: / /	Subscriber's S.S. no.:		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		
IN CASE OF EMERGENCY						
Name of local friend or relative:		Relationship to patient:	Home phone #: ( )	Cell phone #: ( )		

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

PAST MEDICAL / SURGICAL HISTORY

NAME: _____ **DATE: ____/____/_____**

DOB: ____/____/_____ LAST 4 SSN: _____

HEIGHT: _____ WEIGHT: _____

NAME OF YOUR PRIMARY CARE PHYSICIAN_____

PHARMACY NAME / LOCATION: _____

REASON FOR VISIT: _____

WHEN DID SYMPTOMS OCCUR? _____

IS THIS VISIT DUE TO A WORK-RELATED INCIDENT? ____YES ____NO

MARITAL STATUS: _____SINGLE _____MARRIED _____DIVORCED

DO YOU LIVE WITH ANYONE OTHER THAN YOURSELF: ____YES ____NO
IF YES: ____SPOUSE _____FAMILY ____ROOMATE

OCCUPATION: _____

DO YOU HAVE ALLERGIES TO ANY MEDICATIONS? _____YES ____NO
(IF YES PLEASE LIST MEDICATION AND REACTION)

ALLERGIES:

MEDICATION NAME	**REACTION**
_____	_____
_____	_____
_____	_____
_____	_____

PRESCRIPTION MEDICATIONS:

MEDICATION NAME	**DOSE** (mg)	**FREQUENCY**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient's Name: _____

*******Please check what DOES apply********

	YES
IMMUNIZATIONS:	
Flu shot	
Last Tetanus shot	
SURGERIES:	
Appendectomy	
C-Section	
Gallbladder	
Heart Bypass	
Hysterectomy	
Orthopedic	
Stents	
Tonsils	
List OTHER surgeries below	
CANCER:	
Breast	
Colon	
Lung	
Ovaries	
Prostate	
Skin (Type)	
HEART:	
Angina	
Cholesterol	
Congestive Heart Failure	
Coronary Artery Disease	
Heart Attack	
High Blood Pressure	
Eye:	
Cataracts	
Glaucoma	
Genitourinary:	
Kidney Stones	
Renal Disease	
Sexually Transmitted Disease	
GI:	
Hepatitis	
Pancreatitis	
Reflux	
Ulcer	
Crohn's	
IBS	
Diverticulitis	
ENDOCRINE:	
Diabetes	
Thyroid	

	YES
Are you pregnant?	
Last Menstrual Period	
Are you Menopausal?	
MEDICAL SERVICES/ IMPLANTS:	
AICD	
Ports	
Pacemaker	
Joint Replacement	
BONES:	
Arthritis	
Fibromyalgia	
Osteoporosis	
NEUROLOGICAL:	
Migraines	
Seizures	
Stroke	
TIA	
PSYCHIATRIC/ SOCIAL:	
Anxiety	
Bipolar	
Depression	
RESPIRATORY:	
Asthma	
Bronchitis	
COPD	
Pneumonia	
Tuberculosis	
OTHER:	
Sickle Cell	
AIDS	
Anemia	
HIV	
ALCOHOL USE:	
Frequency- (None/Daily/Social/Alcoholic)	
TOBACCO USE:	
Never/ Former/Current- How many?	
FAMILY MEDICAL HISTORY:	
(Relationship to You)	
Cancer/ Type	
Cholesterol	
Diabetes	
Heart Disease	
High Blood Pressure	
Respiratory Problems	
Stroke	

MVA Information

Patient's Name: _____

Date of Birth: _____

Date of Accident: _____

Date of Service: _____

Insurance Name: _____

Insurance Address: _____
_____
_____

Insurance Phone Number: _____

Adjuster's Name: _____

Adjuster's Phone #: _____

Policy Number: _____

Claim # (if available): _____

Attorney's Name:_____

Attorney's Phone #:_____

Health Insurance to be billed as secondary?** Circle YES NO
If YES…please get a copy and full details of insurance carrier from patient (Copy of card and Insured information)

**Please note that it is not a guarantee that health policy will pick up any remaining balance and patient may end up with a balance once accidental policy gets billed.

ASSIGNMENT OF BENEFITS, LIENS, DIRECT PAYMENT AUTHORIZATION, AUTHORIZATION TO RELEASE INSURANCE INFORMATION, AND AUTHORIZATION TO ESCROW UNPAID MEDICAL & PIP BENEFITS

Statmed Quick Quality Clinic of North Pinellas, LLC

INSURANCE CARRIER: _____

CLAIM/POLICY NUMBER: _____ DATE OF LOSS: _____

For and in consideration of Statmed Quick Quality Clinic of North Pinellas, LLC. agreeing to pursue the responsible automobile insurance carrier for payment of benefits due and not requiring prepayment for services, I hereby irrevocably assign all (absolutely all) rights and benefits to Statmed Quick Quality Clinic of North Pinellas, LLC for Personal Injury Protection, extended Personal Injury Protection, Medical Payment Coverage, and other benefits which I may have in accordance with Florida Statute §627.736. This includes any benefits from my insurance company and any other entity which may be responsible for medical expenses incurred. I further authorize Statmed Quick Quality Clinic of North Pinellas, LLC to collect payments & prosecute any necessary actions to collect payment for services as they see fit and allowable by law and contract. THIS DOCUMENT CONSTITUTES AN ABSOLUTE ASSIGNMENT OF RIGHTS AND BENEFITS.

I hereby further give a lien to Statmed Quick Quality Clinic of North Pinellas, LLC against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by Statmed Quick Quality Clinic of North Pinellas, LLC as a result of the above stated loss date. This document acts as an irrevocable and absolute assignment of all of my rights and benefits under all policies of insurance for which I am entitled to coverage thereupon. I agree to cooperate with Statmed Quick Quality Clinic of North Pinellas, LLC and their attorneys (at their choosing), and to do all things reasonable to effect payment of the bills by the insurance company or other entity to Statmed Quick Quality Clinic of North Pinellas, LLC including, but not limited to, disclosing my medical condition, being available for factual discovery or other cooperation.

This assignment concerns the bills for Statmed Quick Quality Clinic of North Pinellas, LLC and those costs including, but not limited to, attorneys fees, other costs, and interest necessary in procuring payment from the above-named insurance company and/or other entities. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deductible or co-payment not covered by any policy of insurance cited above. I understand that as a benefit and convenience to me, Statmed Quick Quality Clinic of North Pinellas, LLC will bill and pursue collection against the insurance company or other responsible entity on my behalf. I hereby instruct and direct my insurance company to pay my benefits directly to Statmed Quick Quality Clinic of North Pinellas, LLC at the address provided on the bill. If my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company or other responsible entity to make the check payable to me and mail it to Statmed Quick Quality Clinic of North Pinellas, LLC at the address on the bill. Statmed Quick Quality Clinic of North Pinellas, LLC's medical care is being provided for a reasonable fee for treatment causally related to the above loss date and is medically necessary. I instruct my insurance carrier or other responsible entity to pay these bills to the full extent of my available benefits under the insurance policy and Florida law. If any portion of the charge for these services is either reduced or denied in whole or in part, my insurance company or other entity is to place funds equal to the amount of the reduced or denied charges into escrow and hold the escrowed funds until agreement or resolution of legal action by Statmed Quick Quality Clinic of North Pinellas, LLC I further instruct my insurance company to make payment for charges submitted by Statmed Quick Quality Clinic of North Pinellas, LLC in priority to any other requests to escrow benefits, including a request by myself to reserve benefits for pending disability claims. I hereby give Statmed Quick Quality Clinic of North Pinellas, LLC limited power of attorney to endorse and sign my name on any draft for payment to either Statmed Quick Quality Clinic of North Pinellas, LLC or myself if said draft represents payment for charges related to services rendered by Statmed Quick Quality Clinic of North Pinellas, LLC.

I further direct my insurance carrier or responsible other entity to provide information to Statmed Quick Quality Clinic of North Pinellas, LLC which is otherwise available to me including but not limited to a copy of any applicable insurance policy, declaration page, all applicable endorsements, transcripts and/or copies of any recorded statements, examinations under oath and requests for same, independent medical evaluations and requests for same, peer review reports and listing of all PIP benefits paid to date which shall include when claim were made, when the claims were received, the payment or denial of each claim, the amount of the deductible and the claims applied thereto, and whether benefits have been exhausted and the amount of PIP benefits available, commonly known as a "PIP log". This request includes the name of other medical providers to whom payments have been made under my policy of insurance. This agreement is intended to serve as an assignment of rights and benefits under my policy of insurance in favor of Statmed Quick Quality Clinic of North Pinellas, LLC If any language within this agreement has the effect of invalidating this agreement, that language shall be deemed void and the remainder of the assignment shall maintain full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

_____ _____ _____

Patient Signature Date Patient Name

If patient is incapacitated or under the age of 18, please indicate the patient name, guardian name and relation to patient, and obtain guardian signature.

ASSIGNMENT OF BENEFITS (AOB) AND LETTER OF PROTECTION (LOP)

Prescription Partners, LLC Clinic Name: _____
2901 SW 149th Avenue, #400 Address: _____
Miramar, Florida 33027 City, State, Zip: _____

ASSIGNMENT OF INSURANCE RIGHTS AND BENEFITS,
DIRECTION TO PAY AND LETTER OF PROTECTION

ASSIGNMENT OF INSURANCE RIGHTS AND BENEFITS:

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby assign, transfer and convey to my health care services provider, (**Clinic Name_____)** (hereafter "Provider") and Prescription Partners, LLC., (hereafter "PP") all of my rights, title and interest in and to medical expense reimbursement for services, including medications dispensed by this Provider, in whatever form, otherwise payable to me for past, present and future payment for services and medications, overdue interest, and any potential claim for common law or statutory bad faith/unfair claims handling. This payment shall not exceed my indebtedness to the above named assignees and I acknowledge that I will timely pay any indebtedness owed by me to the assignees that is not otherwise satisfied by the above-mentioned assigned proceeds which may include my deductible and outstanding balance owed to Provider and PP after my PIP or medical payment benefits have been paid in full.

I further authorize the Provider and PP to negotiate, collect and settle any claim with any insurance carrier or other third-party payor with regard to the services and medications, which authorization shall include authority to (1) request and receive from any insurer or any other party any and all documentation and records that I am empowered to request regarding this claim, including without limitation any policies, declarations pages, statements of coverage, examination under oath transcripts and notices, denial letters, Independent Medical Examination Notices and Reports, Records Review Reports, Explanations of Benefits, and Benefit Payment Sheets or Logs (P.I.P. Payout Sheets), without regard as to whether such documentation has already been provided to me, and (2) file suit to collect payment of insurance benefits or otherwise enforce contractual rights or statutory rights. The insurer is hereby directed to furnish Provider and PP with a copy of the insurance policy and declarations information pursuant to F.S. § 627.4137, copies of all IME reports pursuant to F.S. § 627.736(7), copies of all IME and EUO requests (whether furnish to me are not), as well as an itemized specification of unpaid charges of each item the insurer reduces or denies (including bills applied to a deductible received after policy exhaustion) in accordance with F.S. § 627.736(4)(b) and 627.736(7) this request includes a request for the name and address of the insurer's designated recipient for demand letters and disputes of denials pursuant to F. S. § 627.736(10). If the insurer disputes the validity of this assignment of benefits, then the insurer is instructed to notify the PP in writing within five (5) days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. A photocopy or electronic copy this form shall be considered as effective and valid as the original.

DIRECTION TO PAY: The undersigned directs the insurer to pay PP directly the maximum amount for all medications dispensed by my treating Provider without any reductions and without including the patient's name on the check, to the billing address identified on the medical billing claim forms submitted by PP. In the event patient's name is included on the check, PP is given the power of attorney to: endorse my name on any check for medications dispensed by my Provider. The insurer is directed to pay the bills in the order they are received. Should a bill from PP and a claim from another provider be received by the insurer on the same day the insurer is directed to not apply PP's bill to the deductible. If a bill from PP and claim from another provider is received by the insurer on the same day, then the insurer is directed to pay PP first before the policy is exhausted. In the event PP's bills are disputed or reduced by the insurer for any reason or amount, the insurer is instructed to inform, in writing, PP of any dispute and to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, until the dispute is resolved between the parties or by the Court. Do not exhaust the policy. Any partial or reduced payment regardless of the accompanying language shall be deposited under protest and shall not be deemed a waiver accord, satisfaction, discharge, settlement or agreement by the provider to accept reduced amount as payment in full. The insurer is hereby placed on notice that PP reserves the right to seek the full amount of the bills submitted. *Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above after speaking with the office manager, and mailed to the attention of the Collections Supervisor. See FL Statute 673.3111.*

THIS IS A DIRECT IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY OF INSURANCE.

CERTIFICATION: I certify that: I have read the foregoing and understand and agree to each of the above provisions. I have not been solicited or promised anything in exchange for receiving health care including medications; I have not received any promises or guarantees from anyone as to the results that may be obtained by a treatment; service or medications and I agree the provider's prices for medications and supplies are reasonable, usual and customary.

Patient's Signature:_____ Date:_____
(If a patient is a minor, signature of parent/guardian)
Patient's Printed Name: _____ Date of Accident:_____

Prescription Partners, LLC Clinic Name: _____
2901 SW 149th Avenue, #400 Address: _____
Miramar, Florida 33027 City, State, Zip: _____

LETTER OF PROTECTION: The undersigned patient hereby authorizes and directs my attorney, to pay directly and separately to medical service provider and PP such sums of money that may be due and owed medical service provider and/or owed to PP, for past, present and future medical services and medications resulting from my injuries in my personal injury case ("Outstanding Balance") provided to me by my physician and to withhold such sums of money from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate medical service provider and/or PP. I further agree to, or direct my attorney to, remit payment separately to medical service provider and/or PP depending on the services being billed (i.e. payment for prescription medication should be paid separately and directly to PP, whereas all other medical services provided and billed by medical service provider shall be paid directly and separately to medical service provider). I hereby authorize and grant a lien on my case to medical service provider and/or PP against any and all proceeds of my settlement, judgment, or verdict which may be paid to my attorney or myself, as a result of the injuries for which I have been treated. Once demanded, the Outstanding Balance shall accrue a 10% monthly interest rate until paid in full and in the event this lien is litigated, the prevailing party shall be awarded attorney fees and costs. I agree to promptly notify medical service provider and/or PP of any change or addition of any attorney(s) used by me in connection with this accident and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Patient's Signature:_____ Date:_____

(If a patient is a minor, signature of parent/guardian)

Patient's Printed Name: _____ Date of Accident:_____

The undersigned, being attorney of record for the above patient, does hereby agree to observe all of the terms of this document and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate medical service provider and/or PP.

_____

Attorney Signature Date Signed

Attorney's Name:_____

Address: _____

Phone: _____ Fax:_____