



**Patient Information**

Patient last name: \_\_\_\_\_ First name: \_\_\_\_\_ MI: \_\_\_\_\_  
Patient address: \_\_\_\_\_ Apt: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
Gender: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
Email: \_\_\_\_\_ Phone number: \_\_\_\_\_

**(Workman's Comp Claims Only)** Employer name: \_\_\_\_\_  
Employer address: \_\_\_\_\_  
City, State, Zip \_\_\_\_\_

**Guarantor information**

***If the person financially responsible is anyone other than the patient, complete this section:***

Guarantor last name: \_\_\_\_\_ First name: \_\_\_\_\_ MI: \_\_\_\_\_  
Guarantor address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
Preferred contact number: \_\_\_\_\_ DOB: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_

**Subscriber information**

***If the person carrying the insurance is anyone other than the patient, complete this section.***

Guarantor last name: \_\_\_\_\_ First name: \_\_\_\_\_ MI: \_\_\_\_\_  
Guarantor address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
Preferred contact number: \_\_\_\_\_ DOB: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ SSN: \_\_\_\_\_  
Healthcare insurance company: \_\_\_\_\_  
Member ID/Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**Secondary insurance subscriber:**

Guarantor last name: \_\_\_\_\_ First name: \_\_\_\_\_ MI: \_\_\_\_\_  
Guarantor address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
Preferred contact number: \_\_\_\_\_ DOB: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_  
Healthcare insurance company: \_\_\_\_\_  
Member ID/Policy Number: \_\_\_\_\_ Group number: \_\_\_\_\_

**Consent for Medical Treatment and General Wellness Screening**

**Initial each area:**

\_\_\_\_\_ I give permission to Quick Care to perform the following services that the advanced practice providers and assistants may deem to be necessary: 1) medical, surgical and diagnostic processes, treatments and procedures; 2) administration of injections, medications and immunizations and 3) completion of medically appropriate tests for communicable and other diseases. I give permission to Quick Care to perform preventative health screening. I understand that I am solely responsible for following up with my personal physician or healthcare provider about the results of my screening. In performing the wellness screening, Quick Care does not assume any responsibility for ongoing treatment of management of care.

**Financial Policy**

\_\_\_\_\_ Unless you are here for employer paid services, you will be responsible for either full payment or payment as indicated by your insurance plan. If Quick Care has a contract with your insurance company, we will file today's charges that are with that insurance company. You will be responsible for your co-payment and/or deductible and the cost of any services not covered by insurance. Quick Care will submit claims to your insurance carrier as well as medical records needed to evaluate the claims for payment. I further assign payment of benefits, otherwise payable to me, to be payable to Quick Care. You may receive a bill from Quick Care for any unpaid balance. I understand that I am financially responsible for all charges not covered by my insurance

**Notice of Privacy Practices**

\_\_\_\_\_ I have been made aware of Quick Care's Notice of Privacy Practices (NOPP). You understand that the NOPP is posted and available for review and you will be provided a copy if you request one. If this is your first date of service with Quick Care, please indicate this to the front desk and he or she can provide you with a copy of the NOPP. If you have questions regarding the information in Quick Care's Notice of Privacy Practices, contact Quick Care's management and private office at 1056 29<sup>th</sup> Street SE, Watertown, SD 57201.

**Prompt Pay Discount Eligibility**

\_\_\_\_\_ Payment of the full discounted amount must be made at the time of the office visit. Eligibility for a discount is available to all patients and is not contingent upon insurance coverage, eligibility for Medicaid or any other reimbursement program, unless prohibited by an applicable third-party payor. Medicare patients are not eligible for this program.

\_\_\_\_\_ Any discount will be applied against Quick Care's usual and customary fee for services and not against any contractually reduced fees. Quick Care will not submit discounted fees for services to any third-party payor for reimbursement but will accept payment from third party payors at the time services are provided.

\_\_\_\_\_ The amount of discount is within the sole discretion of Quick Care but is intended to approximate the anticipated costs of billing administration and collection avoided by Quick Care.

**PRINTED NAME:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_