Welcome *to our practice.*

TLC Walk-In Clinic
7900 NW 23rd St.
Bethany, OK 73008
Phone: 405-470-3232
Fax: 405-470-3233

PATIENT INFORMATION

Patient Name: _____

Date of Birth: ____ / ____ / _____ Age: _____ Sex: ☐ M ☐ F

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Best form of contact? ☐ Home ☐ Cell ☐ Work ☐ Other: _____

Home Phone: _____ Leave message? ☐ Yes ☐ No

Cell Phone: _____ Leave message? ☐ Yes ☐ No

Work/School: _____

Social Security #: _____

REASON FOR VISIT: _____

_____

How did you hear about us? _____

Personal Email: _____

Emergency Contact: _____

Emergency Contact Phone: _____

Relationship to Patient: _____

RESPONSIBLE PARTY

Who is financially responsible for this account:

☐ Self
☐ Parent/Guardian
☐ Other: _____

GUARANTOR INFORMATION (IF OTHER THAN SELF):

Name: _____ DOB: ___ / ___ / _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Relationship: _____

INSURANCE INFORMATION

Does patient have health insurance: ☐ Yes ☐ No

Insurance Company: _____

Policy ID: _____ Group #: _____

Secondary Insurance *(if applicable)*

Insurance Company: _____

Policy ID: _____ Group #: _____

Relationship to Insured: ☐ Self ☐ Parent/Guardian ☐ Other: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

Relationship to Insured: ☐ Self ☐ Parent/Guardian ☐ Other: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

MEANINGFUL USE (please read)

Based on government regulations, we are required to ask the following information: ☐ I prefer not to answer

Preferred Language: _____

Ethnicity: ☐ Non-Hispanic or Latino ☐ Other _____
☐ Hispanic or Latino

Race: ☐ American Indian or Alaskan Native ☐ Asian
☐ Black or African American ☐ Caucasian
☐ Hawaiian Native or Pacific Islander

DOCTOR & PHARMACY PREFERENCES

Primary Doctor: _____
Name Phone

Pharmacy: _____
Name Location

ACKNOWLEDGEMENT, CONSENT, & RELEASE

I acknowledge that the information provided in the foregoing Patient Registration & Health History is true and correct to the best of my knowledge. I agree to provide updates and/or changes to this information at any future visits. My initials below indicate I have read, understand, and agree to each section.

Consent to Treat	**Initial**
I consent to medical evaluation and treatment, including procedures, medications, or other interventions as deemed necessary by my treating provider. I understand that services rendered to me at TLC Walk-In Clinic will be performed by licensed physicians or licensed midlevel providers. I understand that urgent care provides episodic medical treatment/stabilization of illnesses or injuries, and that TLC Walk-In Clinic will not take responsibility for ongoing/long-term care of my illness or injury, and after hours care is not available. Lastly, I certify that no guarantee has been, or will be, made to me regarding the result of my treatment.	
Notice of Privacy Practices	**Initial**
Your privacy is very important to us. TLC Walk-In Clinic's HIPAA Privacy Policy & Notice of Privacy Practices is available for patients to review during registration. However, any patient wanting their own copy may request a hard copy from the Registrar at the front desk, or a digital copy can be viewed or downloaded from our website at www.tlcwalkinclinic.net	
Financial Policy	**Initial**
I acknowledge I have read and understand TLC Walk-in Clinic's Financial Policy. I understand that I am ultimately responsible for all charges for services rendered regardless of my insurance status, and that all payments are due at the time services are rendered or immediately upon receipt of a statement indicating an unpaid balance.	
Release of Information	**Initial**
The medical records concerning patient care are the property of TLC Walk-In Clinic and are maintained for the benefit of the patient, the medical staff and the clinic. I hereby authorize TLC Walk-In Clinic to release information and/or copies of my medical records to physicians, any guarantor of payment on my account, insurance companies, and/or any other third party payers. This authorization includes information pertaining to psychiatric and/or psychological care, alcohol and/or substance abuse, and laboratory test results, including those pertaining to HIV/AIDS testing and other communicable diseases. I authorize the provider to use all available means of communication to transmit such information, including by phone, e-mail and/or landline or Internet fax.	
Medicare Patients (& for patients 62 years of age and older)	**Initial**
Patients with Medicare or those who are 62 and older must complete this section. Check the ONE box that best describes your Medicare status.	☐ I am not enrolled in Medicare Part B. ☐ I have Medicare Part B for my primary insurance. ☐ I have Medicare Part B as my secondary insurance. } You **MUST** provide your Medicare card along with any other insurance card.	
Assignment of Benefits	**Initial**
The undersigned, whether signing as a patient, representative, or guarantor, hereby authorize direct payment of any insurance benefits otherwise payable to, or on behalf of, the patient to TLC Walk-In Clinic (herein after referred to as Sang Lee, D.O.). I hereby assign to TLC Walk-In Clinic, all medical benefits otherwise payable to me by virtue of my visit to TLC Walk-In Clinic. I hereby direct insurer to pay such benefits directly to TLC Walk-In Clinic in consideration of professional services rendered to me or my dependent child I understand I may be responsible for payment of any services not covered/ denied by my health insurance.	
Females Only – Radiology Release	**Initial**
I understand that if my condition warrants radiology procedures, it is my responsibility to inform the medical staff if I am pregnant, if pregnancy is a possibility, or if I am unsure of my pregnancy status. I understand that failure to disclose this information could result in harm to my unborn child, and for which I release TLC Walk-In Clinic from any and all liability, seen or unforeseen, by me or my unborn child, and hold harmless their providers, employees, associates, affiliates, etc. now and forever.	

My signature below acknowledges that I have disclosed accurate information, and that I have read and understand all sections above, including any documents incorporated by reference, and I have had any and all questions answered in a manner understandable by me. Although my signature below is a collective acknowledgement of this document, it also serves as a separate signature for each section individually.

_____ _____ ___/___/_____

Patient Name Signature Date

IF PATIENT IS A MINOR:

_____ _____ ___/___/_____

Parent/Guardian Name Signature Date