

Fair Lakes Urgent Care Center

12713 Shops Lane
Fairfax, VA 22033
(703) 222-3555

www.flucc.com

REGISTRATION FORM

PATIENT'S NAME _____
(LAST NAME) (FIRST NAME) (MIDDLE INITIAL)

BIRTH DATE _____ SEX: M / F SS # _____ E-MAIL _____

ADDRESS _____ ZIP _____
(STREET) (CITY) (STATE)

HOME PHONE: () _____ WORK PHONE: () _____ CELL PHONE: () _____

EMPLOYER _____

WORK ADDRESS _____ ZIP _____
(STREET) (CITY) (STATE)

SPOUSE/PARENT/NEXT OF KIN/LEGAL GUARDIAN _____
(LAST/FIRST/MI)

ADDRESS _____ ZIP _____
(STREET) (CITY) (STATE)

SOCIAL SECURITY # _____ CONTACT PHONE: () _____

HOW DID YOU HEAR ABOUT US? SIGNS / PHONE BOOK / INSURANCE / INTERNET / RELATIVES / FRIENDS / OTHER

DO YOU HAVE A PRIMARY DOCTOR? YES / NO; IF ANSWER IS YES;

NAME OF DOCTOR _____ OFFICE PHONE FOR DOCTOR _____

IF YOU DO NOT HAVE A PRIMARY DOCTOR, WOULD YOU WANT US TO BE YOUR PRIMARY DOCTOR? YES / NO;

IF YOU HAVE CHOSEN US YOUR PRIMARY DOCTOR, IT IS YOUR RESPONSIBILITY TO COME IN YEARLY FOR YOUR ANNUAL PHYSICAL. IF YOU HAVE HAD A LAB TEST OR XRAYS HERE, PLEASE CALL US BACK FOR RESULTS IN 2 DAYS.

PRIMARY INSURANCE _____ POLICY # _____ GROUP # _____

ADDRESS _____ ZIP _____ PHONE _____

INSURED NAME _____ BIRTH DATE _____
(LAST/FIRST/MI)

RELATIONSHIP TO INSURED _____ SOCIAL SECURITY # OF THE INSURED _____

DO YOU HAVE A SECONDARY INSURANCE? YES / NO; (IF YES, REQUEST FOR A SECONDARY INSURANCE FORM)

CONSENT FOR TREATMENT/AUTHORIZATION/ ASSIGNMENT/ RESPONSIBILITY STATEMENT

I CONSENT TO HAVE FAIR LAKES URGENT CARE CENTER PHYSICIAN(S) ON DUTY AND THEIR ASSISTANTS AND CONSULTANTS TREAT ME IN THE FACILITY. I CONSENT TO HAVE (1) PHYSICAL EXAMINATION, (2) DIAGNOSTIC PROCEDURES, (3) SURGICAL AND MEDICAL TREATMENT, (4) LOCAL ANESTHESIA GIVEN TO ME IF NECESSARY AND (5) THE PRESCRIPTION OF MEDICATION. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED TO ME, INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURANCE BENEFITS. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS FOR MYSELF TO FAIR LAKES URGENT CARE CENTER AND AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I AGREE TO PAY COLLECTION COSTS AND REASONABLE ATTORNEY FEES INCURRED IN ATTEMPTING TO COLLECT ON ANY OUTSTANDING BALANCES ON MY ACCOUNT. I HAVE READ THIS FORM OR HAVE HAD IT READ TO ME. I AGREE AND UNDERSTAND WHAT IT SAYS.

I FURTHER ACKNOWLEDGE TO HAVE RECEIVED THE NOTICE OF PRIVACY POLICY. I HAVE READ AND UNDERSTOOD IT. I HAVE HAD ALL MY QUESTIONS ANSWERED ON IT. I HEREBY DECLARE TO AGREE TO THE CONTENTS OF THE NOTICE OF PRIVACY POLICY GIVEN TO ME.

SIGNED _____ DATE _____
(PATIENT/PARENT/GUARDIAN/NEXT OF KIN) (M/D/Y)