SCIOTO URGENTCARE

4760 Sawmill Rd
Columbus, OH 43235

Ph: 614-789-9464
Fx: 614-789-9575

Notice of Privacy Policy, Financial Policy, and Consent Form

Patients choosing to use insurance

Scioto Urgent Care is committed to providing you with the best possible care. If you have insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our policies and practices.

If you have insurance, a current insurance card and any copay is due at the time of service. We will be happy to process any insurance claims for you and we accept insurance assignment with our in-network providers. At this time our in-network providers are as follows: Aetna, Anthem Blue Cross and Blue Shield, Bureau of Workers Compensation (BWC), Cigna, Medical Mutual of Ohio, Medicare, OSU Prime Care, and United Health Care. For out-of-network insurance, we require a $50 deposit. Your ultimate responsibility is based on your insurance provider's out-of-network urgent care benefits. We do not accept any form of Medicaid.

Ultimately, your insurance is a contract between you and your carrier. We are not a party to that contract. Any service that is not covered by your insurance company, for whatever reason, is your responsibility.

****Please note that you have the choice to forego using your insurance for any visit. Once your claim is submitted to your insurance company, we can no longer honor the "Prompt Pay" discount offered when not using insurance.**

Patients choosing to be a Self-Pay patient without using insurance

*For self-pay patients seeking a basic office visit, a $120.00 fee is required at the time of your visit. For any additional procedures (diagnostic tests, x-rays, sutures, lab work, etc) there will be an additional fee, required at the time of service. Please ask our front desk staff for these prices.

I hereby acknowledge that I, _____, have read this document and understand my financial responsibility for services provided for myself, and other patients whose names I have provided to appear under my responsibility with Scioto Urgent Care, and the office staff has informed me that if I will be providing an insurance today, whether or not Scioto Urgent Care is in my insurance network, and have received a copy of the Notice of Privacy Practices on this day ___ / ___ / ___. I also give permission for Scioto Urgent Care to give me/my child medical treatment and I understand that I have the right to refuse any treatment.

Patient or Guardian's Signature _____ Date _____

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General Demographics:

Patient's First Name: Last Name: MI:

Marital Status (circle one): S M D W Sex: M F Date of Birth: / / Age:

Home Phone: ( ) - Cell Phone: ( ) - SS#: - -

Street Address: Apt #:

City: State: Zip:

Employer: Work Phone: ( ) -

Employer Address: City:

Primary Physician: Physician's Phone Number: ( ) -

How did you hear about us?:

*If Patient is a Minor:
Parent/Guardian Name: Home Phone: ( ) -

Street Address: City: State: Zip:

SS#: - - Date of Birth: / / Relation to Patient:

In Case of an Emergency:

Emergency Contact Person: Relation to Patient:

Home Phone: ( ) - Cell Phone: ( ) - Work Phone: ( ) -

Medical Information:

List any current medical conditions:

List any surgeries or procedures and the dates:

List all medications you are taking:

List any allergies to medications:

List any family medical conditions:

Insurance Information:

Insurance Company: Policy Holder's Name:

Policy ID #: Group #:

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Patient Consent of Release of Information

What is the primary number to reach you? (___) ___-_____

Are we permitted to leave a message or voicemail with lab or diagnostic results? (Please circle one)

YES NO

Are we permitted to give lab, diagnostic, and/or other test results to anyone? (Please circle one)

YES NO

If yes, please list the names the results may be given to:

_____ _____

_____ _____

Patient Name: _____

Date of Birth: ___/___/___ **Social Security Number:** ___-___-_____

Patient or Guardian's Signature: _____ **Date:** _____