Western Sierra Medical Clinic
Better Health Together

Urgent Care Registration Form

www.wsmcmed.org

PATIENT INFORMATION			
First Name	Middle Name	Last Name	Other Name
Physical Address	City	State	Zip
Mailing Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	
Date of Birth	Social Security #	Email Address	
Emergency Contact	Emergency Contact Phone	Relationship to Emergency Contact	
What is your ethnicity? ☐ Hispanic ☐ Non-Hispanic	Race	Primary Language	
Sexual Orientation: ☐ Lesbian or Gay ☐ Straight (not lesbian or gay) ☐ Bisexual ☐ Something else ☐ Choose not to disclose ☐ Don't know Birth Sex: ☐ Male ☐ Female		Gender Identity: ☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Choose not to disclose ☐ Other	
Are you a Veteran? ☐ Yes ☐ No	Are you a migrant farm worker? ☐ Yes ☐ No	Are you homeless? ☐ Yes ☐ No	
How did you hear about WSMC Urgent Care?		Are you here for an automobile accident? ☐ Yes ☐ No	
Please explain the reason you are here today		Are you here for a work-related injury or illness? ☐ Yes ☐ No	
Date of Injury/Onset of Illness	Current Medications:		
Primary Care Provider (PCP) Note: You must follow up with your PCP after each urgent care visit		Primary Care Provider Phone	

PRIMARY INSURANCE INFORMATION		
Insurance Company	Policy Number	Group Number
Subscribers First Name	Subscribers Middle Name	Subscribers Last Name
Date of Birth	Social Security #	Employer

SECONDARY INSURANCE INFORMATION		
Insurance Company	Policy Number	Group Number
Subscribers First Name	Subscribers Middle Name	Subscribers Last Name
Date of Birth	Social Security #	Employer

RESPONSIBLE PARTY (*Complete ONLY for Minor Patients OR when Patient is NOT financially responsible for account*)			
Name of Person Responsible for this Account		Relation	
Date of Birth	Social Security #	Phone	
Mailing Address	City	State	Zip

PHARMACY CHOICE

☐ WSMC Pharmacy Located at 844 Old Tunnel Road in Grass Valley
☐ Other: Pharmacy Name:_____ City: _____

CONSENT FOR MEDICAL TREATMENT

The undersigned, as the above patient or as the parent, legal guardian or legal representative of the above patient, hereby consents to medical treatment of the above patient by Western Sierra Medical Clinic (WSMC) and its medical providers and clinical staff. Treatment may include any necessary examination, test or medical procedure a WSMC medical provider in the exercise of his/her best judgment may deem advisable for the above patient to be performed by WSMC clinical staff. I understand and acknowledge this authorization is given in advance of any specific diagnosis, treatment or procedure being required to provide specific consent to any and all such diagnosis, treatment or procedure a WSMC medical provider in the exercise of his/her best judgment may deem advisable for the above patient.

I understand the above patient may ask questions and have all questions answered and also may refuse treatment at any time.

If the above patient is seeking substance abuse testing, I authorize WSMC to obtain a specimen pursuant to proper medical protocol to determine the presence of drugs or alcohol.

I understand that some physical exams (like fitness for duty, school, or sports) and other services are not intended to diagnose medical conditions or replace the medical care of the above patient's personal physician.

Signature of Patient/Patient Representative/Parent/Guardian: _____ **Date:** _____

FINANCIAL RESPONSIBILITY

It is the patient's responsibility, and the responsibility of a patient's parent/legal guardian, to pay their share of charges for services provided by WSMC at the time of service, unless other arrangements are made in advance in writing signed by the patient and an authorized WSMC staff member. Payment of a patient's share can be in the form of insurance copays, deductibles, or cash payment for uninsured patients and cash pay patients. Patients not enrolled in health plans are responsible to pay for the entire amount of their bill. Patients enrolled in health plans are responsible for any amount the plan does not pay, up to the entire amount.

WSMC accepts cash, checks, and most major credit cards. A $25.00 fee will be charged for the first check returned by the bank and a service fee of up to $35 for each subsequent check returned by the bank to that same payee.

WSMC does not accept liens or other forms of promised payments for patients who are involved in work-related or personal injuries (e.g., automobile accidents). Patients pursuing claims for work-related or personal injury should consult with their employer and/or the appropriate insurance company for health care needs. WSMC will provide primary care services to a patient pursuing these claims as requested by the patient but the patient remains responsible to pay for all such services in full. WSMC will not bill workers compensation, automobile or other similar insurance company.

Signature of Patient/Patient Representative: _____ **Date:** _____

ASSIGNMENT OF BENEFITS

I hereby irrevocably assign and/or convey directly to Western Sierra Medical Clinic, Inc. and/or its contracted healthcare providers (hereinafter "WSMC"), as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by WSMC for treatment/services rendered by WSMC, regardless of its managed care network participation status. This Assignment of Benefits shall apply to all insurance coverage, including but not limited to the Centers for Medicare and Medicaid Services, its intermediaries, carriers or administrative contractors, State Medicaid programs, or any other governmental or commercial insurance. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. This assignment is valid until revoked in writing. A photocopy of this assignment is to be considered valid, the same as if it was the original.

Signature of Patient/Patient Representative: _____ **Date:** _____

ACKNOWLEDGEMENTS

1. I have read WSMCs Notice of Privacy Practices.
2. I may voice any concerns or grievances by contacting WSMC's Patient Advocate at (530) 274-9762 ext. 193.
3. I may not record, photograph or videotape inside a WSMC site.
4. I am solely responsible to safeguard and protect my personal property. WSMC is not responsible for safeguarding or for the theft, loss or damage to my personal property. I release all claims against WSMC for loss, theft or damage to my personal property.

Signature of Patient/Patient Representative: _____ **Date:** _____

Western Sierra Medical Clinic does not discriminate on the basis of race, color, national origin, age or disability, ethnicity, religion, culture, language, sex, physical or mental disability, socioeconomic status, sexual orientation, or gender identity or expressions.