FIRST Kids

Reason for Visit: **COVID TEST** ☐ **PCR** ☐ **RAPID** ☐ **FLU** ☐ **STREP** ☐ **RSV**

Kindly fill out this entire section

Today's Date:_____ **Last Name:** _____ **First Name:** _____ **MI**_____

SSN: _____ **Date of Birth:** _____ **Male [ ]** **Female [ ]**

Primary Phone Number:_____ **Secondary Phone Number:**_____

****Email Address (please provide valid email address for patient portal:)**_____

YOUR PATIENT PORTAL WILL BE USED TO VIEW AND PRINT YOUR COVID-19 TEST RESULTS.

Billing Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Insurance Type:_____ **Insurance Policy Holder:**_____ **Policy's Holder DOB:**_____

Allergies: _____ **Medical Conditions: Diabetes [ ] Hypertension [ ] Other:** _____

Pharmacy + Location (Where your prescription will be sent to if needed) _____

_____

In case of emergency, please contact:

Name: _____ **Primary Phone:**_____

It is Complete Wellness/Crimson Care Network's policy that we collect co-pays and past due balances before you see the doctor. If there are any changes to your insurance since your last visit, please provide that information to the receptionist. We will bill your insurance as a courtesy to our patients, but it is the patient's responsibility to provide accurate insurance information to our office.

MEDICAL RELEASE FORM

I give Crimson Care and First Care permission to release my medical records: Yes [ ] No [ ]

Signature: _____

I Allow My Records To Be Sent or Viewed By:

To Whom It May Concern:_____**FAX:**_____

Address:_____ **Phone:**_____

AGREEMENT TO PAY: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary.

You agree, in order for us to service your account or to collect monies you may owe, Complete Wellness/Crimson Network and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable. I/We have read this disclosure and agree that Complete Wellness/Crimson Network its employees and/or agents may contact me/us as described above.

_____ _____

Responsible Party Signature **Date**

PLEASE COMPLETE BACK PAGE ->

INSURANCE INFO IF YOU DO NOT HAVE A HARD COPY OF YOUR CARD:

TYPE:
GROUP NUMBER:
POLICY NUMBER:
POLICY HOLDER NAME AND DOB:
ADDRESS ON BACK OF CARD:

COVID CHECK IN SHEET PLEASE FILL OUT!!

THIS BOX IS FOR OFFICE USE ONLY

- ☐ PCR
- ☐ RAPID
- ☐ NEGATIVE
- ☐ POSITIVE
- ☐ CALLED

LAST NAME:
FIRST NAME:
MIDDLE NAME:

(CIRCLE or CHECK)

EXPOSURE
BODY ACHES
CHILLS
SORE THROAT
SCHOOL REQUIREMENT
FEVER
NAUSEA
SHORTNESS OF BREATH
UPCOMING PROCEDURE
WORK REQUIREMENT
NASAL CONGESTION
VOMITING
COUGH
DIARRHEA

OTHER- EXPLAIN:

Assignment of Insurance Benefits and Payment Guarantee Initials In consideration of services provided by Complete Wellness/ Crimson Network. I hereby assign and transfer to Complete Wellness/Crimson Network any and all rights which I have against insurance companies, governmental agencies, or third-party payers, for payment of charges for services provided by Complete Wellness/Crimson Network to me or to one of my dependents. I understand that I am responsible for and will pay the portion of my bill not covered by insurance companies, governmental agencies or third-party payers. In consideration of services to be provided, I agree to pay Complete Wellness/Crimson Network in accordance with the regular rates and terms. I understand that as a contractual obligation with insurance companies, all copays and high deductibles are due at the time of service and that a balance still may be due after the insurance payment has been applied.

Signature Initials I certify that the information provided is correct to the best of my knowledge. I will not hold Complete Wellness/Crimson Network, its health providers, or its employees responsible for any errors or omissions that I may have made in completing the information on this form. I hereby voluntarily consent to treatment for me or my dependent at Complete Wellness/Crimson Network and authorize such treatments, examinations, medications and diagnostic procedure (including, but not limited to the use of lab and radiographic studies) as ordered by its providers. I hereby voluntarily consent to the taking of photographic images for treatment purposes only (wound care progression, documentation of rashes, etc.) as ordered by such providers.

Print Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____