Medi-Station
Urgent & Walk-in Medical Care

Patient Name_____ Male ☐ Female☐

SS# _____ Date of Birth _____Married☐ Single☐ Other _____

Address_____
Unit # City State Zip

Home Phone _____ Cell Phone _____

Can we leave a message on your preferred phone? ☐Yes ☐No

Patient e-mail address is
Required for Patient Portal access_____

Race: ☐ American Indian or Alaskan Native ☐Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐White ☐ Other ☐ Decline

Preferred language_____ Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino

Primary Care Physician Name _____Phone_____

Pharmacy _____Location_____Phone_____

Person Financially Responsible for account _____

Emergency Contact_____Phone#_____

How did you learn about Medi-Station? ☐ Driving By ☐Friend/Family ☐Doctor Referral ☐Am Existing Patient ☐Internet ☐Insurance Company ☐Other_____

Today's Payment
How will you be paying for today's bill? ☐Patient Pay I will be paying the full bill today using ☐Cash ☐ Debit Card ☐Credit Card ☐Insurance ☐Auto Insurance (accident) ☐Worker's Compensation Claim

Insurance Information
Primary Policy Holder _____
SS# _____DOB_____
Relationship to subscriber ☐Self ☐Spouse ☐Child ☐Other_____
Employer of Insured Person _____
Insurance Carrier_____
Member ID_____Group #_____
Do You Have Insurance with more than one Health Plan? ☐Yes ☐No
If Yes, Please present both ID cards and Drivers License at check-in

I hereby authorize direct payment of medical benefits to Medi-Station for activities rendered by the employees. I understand that I am financially responsible for any balance not covered by insurance. I certify that all information is correct and authorize Medi-Station to release any information for either medical care or in processing applications for financial benefits.

Signature _____Date_____

Office Policies

Financial Policy

This is an agreement between Medi-Partners of South Florida, dba Medi-Station, as creditor, and the Patient/Guarnator named on this form. By executing this agreement, you are agreeing to pay for all services that are received.

Payment options if you have NO insurance or insurance companies we do NOT accept:

You choose to pay by __cash, __debit Card , or __credit card on the day that treatment is rendered.

Payment options if you have insurance:

You are responsible to pay your co-pay, deductible, and any out-of-pocket portions at the time services are rendered by __cash, __debit card , or __credit card.
You are responsible for any coinsurance or amount stated per your insurance explanation of benefits.

Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill primary and secondary contracted insurance companies only. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. We are not a Medicaid provider, we cannot send billing to the Department of Job and Family Services on your behalf. If you are a Medicaid recipient, you will be financially responsible for your services today.

Returned checks: There is a fee (currently $40) for any checks returned by the bank.

Workers Compensation: We require you to notify us at the time of visit that this is due to a work related situation. Failure to do so will make you financially responsible for this bill. If your claim is denied, you will be responsible for payment in full.

OUTSIDE LAB SERVICES: If you need more comprehensive lab work, some tests may not be covered by your insurance carrier. In that case, you may receive an additional bill/statement for these services from the outside laboratory. Medi-Station will make every attempt to advise you of the costs prior to testing.

Patient's name:_____
Responsible party
(if not the patient):_____

Signature:_____ Date:_____

Notice of Privacy Practices: I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law and outling my rights regarding my health information. If you have any questions regarding the information in Medi-Station's Notice of Privacy Practices, you may contact the Privacy Officer for Medi-Station at 305-603-7650.

Name (please print): _____

Signature:_____ Date_____
Responsible party
(if not the patient):_____

Medical Record Release:

I, _____, hereby authorize release of my medical record information to my primary care Physician. I understand that this authorization may be revoked at any time.

Signature _____ Date _____

Medical Release for a Minor Child:

I, _____, Parent or Legal Guardian of _____, (Name of Minor Child), hereby authorize Medi-Station to perform any Medical or Surgical treatment which may be necessary for the well being of the above mentioned minor. I agree to hold Medi-Station and the physician harmless for rendering such care.

Signature: _____ **Date:** _____

Name: _____ **Date:** _____

Main reason for today's visit:_____

Have you ever been hospitalized?	Date	Have you ever had any surgery?	Date

Do You Smoke?	Y	N	If Yes, how much?
Do You Drink Alcohol?	Y	N	If Yes, how much?
Do You Exercise?	Y	N	If Yes, how much?

Allergies: _____ ☐ **None**

I am Taking the Following Medication: (or Provide a Photocopied List)

☐ **None**		

Have you ever had?	Yes	No	Have you ever had?	Yes	No
Asthma			High Blood Pressure		
Vision/ Hearing Problems			Rheumatoid Arthritis		
High Cholesterol			Osteoarthritis/ Osteoporosis		
Blood Clot in Lungs			Epilepsy/Seizures		
Kidney Disease			Stroke		
Prostate Problems			Diabetes Mellitus		
Liver Disease			Thyroid Problems		
Hepatitis			Anemia		
Pancreatitis			Coagulation Problems		
Diverticulosis/Diverticulitis			Cancer (including Skin Cancer)		
Gastritis/Ulcer/ Reflux			Sleep Apnea		
Heart Attack/ Angina			Chronic Muscular Disease		
Bypass or Stent Placement			Chronic Neurological Disease		
Pacemaker			Skin Disease or Rashes		
Valve Heart Disease			Psychiatric Treatment		
Heart Failure			Chronic Pain		
HIV Positive /Aids			Eating Disorder		

Family History: ☐ High Blood Pressure ☐ Cancer of _____ ☐ **None**
☐ Coronary Artery Disease ☐ Diabetes

Women's Health History: # Pregnancies ____ # Deliveries _____ # Abortions _____ # Miscarriages _____

First day of most recent period: _____ Birth Control method: _____ Age of Menopause onset _____

I certify that the information provided is correct to the best of my knowledge. I will not hold Medi-Station or its employees responsible for any errors or omissions that I have made in completing the information on this form.

Signature:_____**Date**_____