Memorial PRIMARY CARE | URBANA

900 Scioto Street
Urbana, Ohio 43078
(937) 652-1834

Welcome New Patients:

Thank you for selecting Memorial Primary Care | Urbana, affiliated with Memorial Health, for your healthcare needs.

This letter and the attached information will acquaint you with our office policies. All forms must be completed and returned to our office prior to your first scheduled appointment.

Our office is open Monday through Friday 7:30 am to 5:00 pm. We have a physician on call 24 hours a day, seven days a week. If you have an **emergency situation** always call 911 first. For other after hours issues, you may call the office and you will be given instructions for reaching the doctor on call. The on-call doctor will call back as soon as time permits. Be sure to clearly state your name and phone number. Please do not use this service for routine requests including routine prescription refills or appointment and scheduling issues.
Patients are seen by appointment only. If you are a new patient, please arrive 15 minutes early for your first appointment and five to ten minutes early for routine appointments afterwards. Always check in with one of the staff at the window and be prepared to pay any co pays or deductibles or balances. Please bring all your current medications and your health insurance cards with you. After your first appointment, you will be asked to present your current insurance card each time you check in for an appointment.

We ask that if you cannot keep your scheduled appointment, kindly give us at least 24-hours notice so that we may give your appointment to another patient. We reserve the right to charge you for a missed appointment. Additionally, if you schedule an urgent/sick appointment and miss that appointment, you will be charged
$25.00. Finally, if you show up more than 15 minutes late for an appointment, you may be rescheduled. The decision to reschedule is at the discretion of the physician.
You may call in to request prescription refills; however, we cannot guarantee the timeliness of the request. You must allow **48 to 72** hours for the doctor to review your request, and process your prescription.

As you are free to change doctor's at any time, likewise, we are free to dismiss a patient from the practice if we believe the patient to be non-compliant, fails to keep appointments, or if you fail to honor your financial obligations. It is our policy that once dismissed for any reason; you will not be reinstated into the practice. All dismissals are done in accordance with State law regarding such matters.

We look forward to serving your medical needs. If you have any questions regarding any of the information included in this packet, please contact our office.

Sincerely,

The Staff of Memorial Primary Care | Urbana
Look for us on Facebook – www.facebook.com/familyphysiciansofurbana

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PATIENT INFORMATION FORM

PLEASE PRINT

PATIENT'S NAME:	First:	MI:	Last:
ADDRESS:			
CITY:		GENDER: Male____ Female ____	
HOME PHONE:		CELL PHONE:	
SOCIAL SECURITY #:		DATE OF BIRTH:	
MARITAL STATUS: Married _____ Single_____ Divorced _____ Widowed _____			
PREFERRED LANGUAGE _____ RACE: (circle one) White Black/AA Asian American Indian Native Hawaiian/Pacific Islander DECLINED ETHNICITY: (Circle one) Hispanic/Latino Not Hispanic/Latino DECLINED E-MAIL ADDRESS:			
PHYSICIAN ASSIGNED (Office Use Only)			
DOES A MEMBER OF YOUR FAMILY HAVE AN ACCOUNT WITH US? Yes ___ No ___			
YOUR EMPLOYER'S NAME:			
EMPLOYER'S ADDRESS:			
EMPLOYER'S PHONE NUMBER:			

NAME OF NEAREST RELATIVE OR FRIEND NOT IN SAME HOUSEHOLD:

Name: _____ Relationship: _____

Address: _____ Phone Number: _____

INSURANCE COVERAGE (Please provide a copy of insurance cards)

PRIMARY INSURANCE:

Insurance Company: _____ Policy #: _____

Subscriber's Name: _____ Group #: _____

Subscriber's Date of Birth: _____ Subscriber's Social Security Nr. _____

SECONDARY INSURANCE:

Insurance Company: _____ Policy #: _____

Subscriber's Name: _____ Group #: _____

Subscriber's Date of Birth: _____ Subscriber's Social Security Nr. _____

PHARMACY: _____

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. If I do not pay my balance within 90 days of the monthly billing date, a late charge of 1% on the balance then unpaid and owed will be assessed each month. I realize that the failure to keep this account current may result in the doctor being unable to provide additional services.

_____ _____

Signature of patient or parent if minor Date

OFFICE USE ONLY:
Received by:_____ Reviewed by:_____ Approved By:_____ Entered By:_____ Scanned by:_____