MAKE YOU WELL
Urgent Care + Family Practice

23365 Hawthorne Blvd. STE 104
Torrance Blvd, CA 90505
Phone: (424) 292-4060 Fax: (424) 567-8195

Patient Demographic Form

Patient information:

Last Name: ____________________________________ First Name: ______________________________________
SSN #: _______________________________________Date of Birth: _____/_____/______ Sex: M F
Address: ____ Apt: ___________
City: ____ State: ________ Zip Code: __________________
Home Phone: (____)_______________ Cell Phone: (____)_____________Work Phone: (____)________________
Race (optional): _________________ Language: ___________Email Address: ______________________________
Marital Status: S M D W Employer: ____
Emergency Contact Name: _________________________________ Relationship: ________________________
Emergency Contact Phone #: (____)_______________________
How did you hear about us? Yelp / Google / Drive By / Word of Mouth / Other _________________________

Insurance Policy Holder Information: Please provide insurance cards

Policy Holder's Name: ____________________________ Date of Birth: ____/____/____ SSN #: ______________
Address: ____________________________________ Apt: ___City: ________________State: _______ Zip ________
Phone #: (____)_______________ Cell #: (____)_______________
Insurance Company: ____________________________________ Insured's ID#: ____________________________
Policy Group ID #: _____________________________________ Social Security #: ___________________________
Insurance Plan Name/ Program: _____________________________ Policy Holders Relationship: ______________

Primary Care Provider & Pharmacy Information:

Primary Care Provider: ____
Address: ________________________________City: _________________ State: _______ Zip Code: ____________
Phone #: (____)_______________ Fax #: (____)_______________

Pharmacy Name: ____
Address: ____ City: _________________________
State: ______ Zip Code: ____________ Phone #: (____)_______________ Fax #: (____)______________________

Please **read** and **sign** the following agreement so that we may proceed with your care and treatment at Make You Well.

I hereby authorize my insurance benefits to be paid directly to Make You Well. I understand and am responsible for all charges including my added costs incurred due to an effort to collect for services rendered. I realize I am responsible to pay for non- covered services and I hereby authorize the release of pertinent medical information to the insurance company.

____ ______________________

Signature of Patient Date

CONSENT TO MEDICAL CARE: The undersigned hereby consents to the procedure that may be performed today as well as in the future during outpatient treatment, including emergency services, or other services, or other services rendered under general and special instructions of my health care provider.

FINANCIAL AGREEMENT: The undersigned, whether signed as a patient or representative of the patient, agrees to pay all charges for medical services not otherwise covered by health care benefits, in accordance with the rates of Make You Well. If the account is referred to an attorney or collection agency, the undersigned agrees to pay actual collection costs, including attorney's fees, together with interest at the legal rate.

ASSIGNMENT OF BENEFITS: The undersigned, whether signed as a patient or representative of the patient, authorizes direct payment to Make You Well of any health care coverage benefits otherwise payable to or on behalf of the patient for medical services rendered to us, including emergency services, if any. Health care coverage benefit include Medicare, PPO, EPO, POS, HMO, other government issued health care benefits, as well as coverage under Workers' Compensation, automobile, life/accident, and disability insurance plans, The undersigned authorizes release of medical information necessary to determine the eligibility and benefits payable and to submit and process claims for payment.

WAIVER OF OUTSIDE LABORATORY AND RADIOLOGIST: The undersigned, whether signed as a patient or representative of the patient understand that Make You Well may send lab specimens to an outside laboratory or send X-Rays taken by Make You Well to an outside Radiologist for reading. The undersigned, whether the patient or representative of the patient, understands that they may incur additional charges as a result and understands that Make You Well is not responsible for payment to those laboratories and radiologist.

CORONAVIRUS TESTING CONSENT
In the event that I or my employer request a Covid-19 test, I authorize Make You Well Center, Inc. to conduct collection and testing for COVID-19 through a nasaopharyngeal swab. I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law. I acknowledge that I have read and understand the above and further agree to hold harmless Make You Well Center, Inc, including its employees, agents, and contractors from any and all liability and claims.

RELEASE OF MEDICAL INFORMATION: The undersigned, whether signed as a patient or representative of the patient, authorizes Make You Well to release the medical records covering my son/ daughter/ self to any physician, hospital, or agency involved in the care of the patient listed.

WAIVER OF ON SITE PRESCRIPTION PROGRAM (OPTIONAL): The undersigned, whether signed as a patient or representative of the patient, has an option to have your prescription purchased from Make You Well. We do not participate in prescription insurance program, and will not refund any prescription for any reason.

NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California (800) 633 – 2322. www.mbc.ca.gov

THE UNDERSIGNED CERTIFIES THAT HE OR SHE HAS READ AND UNDERSTANDS THIS FORM, AND ACCEPTS, AND AGREES TO ABIDE BY ITS TERMS.

____ ____________________

Signature of Patient Date