RediCare
WALK-IN URGENT CARE

4185 E. Grand River, Howell, MI 48843 (517)546-9200

Patients Last Name _____ First Name_____MI_____

Sex: M F Date of Birth _____ Social Security #_____ Marital Status: _____

Street Address _____ Apt _____ PO Box _____

City _____ State _____ Zip _____ Email_____

Phone Number: (circle: Cell/Home) _____Contact Preference: circle: email/phone/mail

Emergency Contact Name _____ Relationship _____

Emergency Contact Phone Number (circle: Cell/Home)_____Birth Date _____

Preferred Pharmacy _____City_____ Cross road_____

Primary Care Physician _____ Phone Number _____

(Please fill in the blanks) **Insurance Information (Card Not Needed)**

Primary Insurance _____ Subscribers Name _____

Subscribers Address_____Zip Code_____

Telephone number_____TriCare S.S. #_____

Subscribers Date of Birth _____ Relationship to Insured _____

Secondary Insurance _____ Subscribers Name _____

Subscribers Address_____Zip Code_____

Subscribers Date of Birth _____ Relationship to Insured _____

A$5.00 processing fee will be added for copays not collected at time of service.

We only par with McLaren and Health Plus Medicaid, we do NOT par with any other form of Medicaid.

Most laboratory services will be done at an outside lab (i.e. St Joseph Mercy). Please be aware that there will be a separate bill from the lab for these services. If your insurance company requires that your lab tests be done at a designated facility, you will need to inform us of this each time lab tests are being ordered. You are ultimately responsible for compliance with your insurance rules and requirements and for any charges related to lab work.

I acknowledge my rights as assigned thru the Notice of Privacy Practices. A copy of this notice is available upon request. I also request that payment of authorized insurance carrier benefits be made on my behalf to Howell RediCare for any services furnished by this provider. I authorize any holder of medical or other information about me to release to my insurance carries any information needed to determine their benefits for related services. I also authorize RediCare to access my medication history through the electronic pharmacy network.

Signature_____ Date _____

I give my permission for my medical information to be released to the following individuals

Name:_____Relationship_____