PLEASE DO NOT COME INTO LOBBY IF YOU THINK YOU HAVE COVID-19. There will be a triage nurse outside the building to consult with you. If no one is present, please remain in your vehicle and call our office, and someone will be with you shortly. If your insurance is not verified we will not be able to send off your results until this is resolved.

CRIMSON NETWORK
PRIMARY + URGENT CARE

SKYLAND
(P) 205-507-1119 (F) 205-507-1113

VETERANS
(P) 205-507-1100 (F) 205-553-3318

FIRST CARE
(P) 205-349-2323 (F) 205-349-1155

Kindly fill out this entire section

Today's Date:_____ Full Name: _____

SSN: _____ Date of Birth:_____

Primary Phone Number:_____ Secondary Phone Number:_____

Email Address:_____ Consent Expiration:_____

Billing Address:_____

City:_____ State:_____ Zip Code:_____

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

Reason for Visit:_____

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

_____

In case of emergency, please contact:

Name: _____ Primary Phone:_____

It is Crimson Care'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.

CIRCLE ONE: REASON FOR TEST PROCEDURE EXPOSURE SYMPTOMS OTHER

PLEASE FILL OUT YOUR VEHICLE INFORMATION FOR US TO EASILY LOCATE YOU

MAKE/MODEL/COLOR _____

Please wait 48 hours for results. After 48 hours you may contact us.

MEDICAL RELEASE FORM

Date: _____ DOB: _____

Patient Name: _____

Primary Phone: _____ Secondary Phone: _____

Address:_____

Email:_____

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

Signature: _____

Send My Records To:

Company Name:_____ FAX:_____

Address:_____ Phone:_____

Email:_____

Assignment of Insurance Benefits and Payment Guarantee Initials In consideration of services provided by Complete Wellness Group. I hereby assign and transfer to Complete Wellness 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 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 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, 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 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: _____