MAXEM HEALTH MEDICAL DISCOUNT PATIENT REGISTRATION

Patient Information

Patient Full Name:

Reason for Visit:

Date of Birth: Gender: ☐ Male ☐ Female

Social Security #: Ethnicity/Race:

Local Address: Apt #:

City: State: Zip:

Primary Phone #: ☐ Home ☐ Cell ☐ Work

Secondary Phone # : ☐ Home ☐ Cell ☐ Work

Email Address: By providing your email address, you consent to our Email Privacy Policy

How did you hear about us?

☐ Location ☐ Customer Service ☐ Email ☐ Facility Signage
☐ Family/Friend/Word of Mouth ☐ Internet/Online Search ☐ Print Advertising
☐ Radio ☐ Phone Book/Yellow Pages
☐ School/Daycare: ________________ ☐ Employer: ________________
☐ Community Event: ______________ ☐ Hotel: __________________
☐ Physician Referral: ______________ ☐ Pharmacy: ________________
☐ Apartment Complex: _____________ ☐ Insurance: ________________

Marital Status: ☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouse's Full Name:

Permanent Address (other than local):

City: State: Zip:

Primary Care Physician:

Employer:

Parent/ Legal Guardian of Minor or Incapacitated Adult Only

Full Name: Date of Birth:

Relationship: Contact #:

Maxem Health Members agree to the following terms and conditions:

I acknowledge that I understand that Maxem Health membership fees will be withdrawn every 30 days for membership benefits and will be automatically deducted from the payment details I have provided on a month-to-month basis. I understand that monthly billing will begin after my 90 day pre-paid period expires.

I acknowledge that Maxem Health's Medical Discount program is not Insurance, and is not replacing any insurance.

I acknowledge that my Maxem Health membership cannot be used to bill my insurance for the care I received within a Maxem Health Urgent Care and its participating clinics and cannot be used with any U.S. government plan including, but not limited to Medicare and Medicaid.

I acknowledge that if I wish to cancel my Maxem Health membership, I must submit a request 10 days before my next billing cycle to ensure appropriate time to process my account. Cancellation requests may be submitted in the following ways:

Email: mxmhealthmedicaldiscount@gmail.com
Fax: 228-382-9224
Call: 228-223-1927
Clinic: Go to your local clinic and fill out the Maxem Health Medical Discount cancellation form

I acknowledge that the following fees are not covered by my Maxem Health membership: Durable Medical Equipment (Crutches, Splints, etc.); this service is provided and billed through an outside vendor, but may be covered by your insurance plan. Services performed by outside facilities will be billed to you or your insurance company separately by the providing institutions (ex: ER, Specialists, MRI's, CT scans, and laboratory services not provided within our participating urgent care clinic). Prescriptions, Immunizations/vaccines are also not covered.

I have read and understand the membership information above regarding membership benefits and enrollment. I understand that the Maxem Health Medical Discount Program only applies to select services provided by a participating urgent care clinics of Maxem Health Urgent Care, and that I will be responsible for any fees, at the time of service, incurred for services outside of the membership program. I also understand that I may never seek reimbursement from any health insurance and Maxem Health Urgent Care will never bill for services I receive as a Maxem Health subscriber.

DISCLAIMER: MAXEM HEALTH URGENT CARE'S MEDICAL DISCOUNT PROGRAM DOES NOT REPLACE YOUR CURRENT INSURANCE, OR COVER ANY OUTSIDE MEDICAL BILLS, ER VISITS, OR SPECIALISTS VISITS.

Signature

Patient's Name: Date:

Signature: