A Division of The Center for Urgent Care

Patient Information Form

First Name:_____ **Last Name:**_____ **MI**:_____

Date of Birth:_____
Gender: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced
Do you reside at an Adult Living Facility? If yes, name of facility:
_____

Home Address:_____

City:_____ **State:**_____ **Zip:**_____ **Email:**_____
*We do not share your email with any outside vendors, but if you wish for us NOT to use your email to share updates & educational information, initial here:____

Preferred Phone: _____ ☐ Cell ☐ Home ☐ Work
Secondary Phone:_____ ☐ Cell ☐ Home ☐ Work

Local Pharmacy:_____ Cross Streets or Phone #:_____

Language: ☐ English ☐ Spanish ☐ Other:_____

Race: ☐ African American ☐ White ☐ Asian ☐ American Indian ☐ Prefer not to answer ☐ Other: _____

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Prefer not to answer

Emergency Contact Name:_____ **Relationship:**_____

Phone #:_____ Address:_____ City:_____ State:___ Zip:_____

HIPAA: Please list anyone with whom we may discuss your health information:
May we discuss your private medical information with your Emergency Contact? ☐ Yes ☐ No

Please list anyone else you authorize us to discuss your private health information.

Name/Relationship:_____ Phone:_____
May we obtain your medical records from your other healthcare providers, hospitals, or other healthcare facilities that are available to us through interlinked healthcare provider portals? ☐ Yes ☐ No

Guarantor, who is responsible for the bill: ☐ Self ☐ Parent ☐ Same as Emergency Contact

☐ Other: Name:_____ Relationship:_____

Phone #:_____ Address:_____ City:_____ State:___ Zip:_____

How did you hear about us? ☐ Google ☐Mailer ☐ Facebook ☐ Word of Mouth

☐ Physician:_____ ☐ Attorney:_____ ☐ Other:_____

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CONSENT FOR MEDICAL TREATMENT

Patient Name: _____ Date of Birth: _____

As the patient/authorized representative, I am requesting to receive medical evaluation/treatment services.

I understand that:

- I have the right and am encouraged to discuss any medical treatments with my provider.
- I have the right to refuse any procedure or treatment.
- I consent to have photographic images be taken for the purpose of patient identification and documentation of medical conditions. I understand these photographs are protected patient information and will not be shared beyond the purpose of medical care without my written consent.
- Care may include, but is not limited to, medical evaluation, diagnostic laboratory and radiological procedures, and the administration of medications and therapies considered advisable in my diagnosis, treatment, and course of care.
- I acknowledge that no guarantee can be made or has been made as to the results of treatments or examinations and I understand that all medical treatments contain inherent risks.

Privacy Practices

The security of your protected health information is the highest priority to us. We have developed Privacy Practices to inform you how we safeguard your information. We provide the notice of these practices to our patients. You may choose to decline review

___I have received a copy of the Privacy Practices

___I do not wish to receive a copy of the Privacy Practices

I understand that I may ask questions to the staff at any time regarding the use and protection of my protected health information.

Patient Signature:_____ Date: _____

If patient is a minor or legally unable to give consent:

Parent/Guardian Name (Please Print):_____

Parent/Guardian Signature:_____ Date: _____

Relationship: ☐ Parent ☐ Legal Guardian ☐ Medical Power of Attorney

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FINANCIAL POLICIES & PRACTICES CONSENT

It is your responsibility to provide us with your most current insurance information:

- If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you may be financially responsible for services rendered.
- We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company, and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.
- We may accept assignment after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. You are financially responsible for services not covered by your insurance company.
- Before receiving services, you must verify that we are participating providers for your insurance company. If we are not party to that contract, payment is due in full at the time of service.
- If we participate with your insurance co-payments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have processed your claim – regardless of our estimation.
- We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

It is your responsibility to provide us with your most current billing information.

- You must provide your most current billing address, all available telephone numbers and any other important contact information. If you address or contact information changes, it is your responsibility to contact us with the updated information. We will send a statement.
- In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add an additional charge to your original balance.

Services provided outside of the facility:

- When laboratory studies, diagnostic tests, or referrals to other providers are needed that are not performed within our facility, we will provide your insurance information to those entities (ex. Quest Diagnostics, International Medical Lab [IML]) so they may file on your behalf. However, any associated fees/copays/coinsurance/deductibles will be your responsibility. The Center for Urgent Care is not privy to the fees and prices any other medical service provider charges.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand that the practice may amend such terms from time to time as necessary.

Patient Signature:_____Date:_____

If patient is a minor or legally unable to give consent:

Parent/Guardian Name (Please Print):_____

Parent/Guardian Signature:_____Date_____

Relationship: ☐ Parent ☐ Legal Guardian ☐ Medical Power of Attorney

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Medical History Questionnaire

Name _____ **Birth Date**_____ **Today's Date**_____

Reason for visit: _____

What symptoms are you experiencing?: ___N/A _____

_____

Are you allergic to any medications, foods or substances? ___No ___Yes, please list:_____

_____

Do you take any medications or supplements? ___No ___Yes, please list:_____

_____

_____

Medical Conditions: NOW or in the PAST (Please check all that apply) ☐ No Medical Conditions

☐ Anxiety/Depression	☐ Thyroid Disease	☐ Tuberculosis	☐ Bleeding Disorder
☐ High blood pressure	☐ Stroke/TIA	☐ Seasonal Allergies	☐ Kidney Disease
☐ Heart Disease/Angina	☐ Diabetes	☐ Reflux/GERD	☐ Prostate Disease
☐ Heart Stents	☐ Asthma	☐ Diverticulitis	☐ Arthritis
☐ CHF (heart failure)	☐ COPD/Emphysema	☐ Glaucoma	☐ Osteoporosis
☐ High Cholesterol	☐ Pneumonia	☐ Seizures	☐ Cancer:_____
☐ A Fib	☐ Pulmonary Embolism	☐ HIV	☐ Hepatitis A, B, C

Other Medical Conditions not listed:_____

Prior Surgeries:_____

Family Medical History:

Mother: ☐ Living ☐ Deceased Medical Condition: _____

Father: ☐ Living ☐ Deceased Medical Condition: _____

Sibling: ☐ Living ☐ Deceased Medical Condition: _____

Tobacco Use: ☐ Never ☐ Quit - When? _____ ☐ Yes - If yes, how many packs per day?_____

Do you drink Alcohol? ☐ No ☐ Yes - If yes, how much? _____ ☐ daily ☐ weekly ☐ monthly