Premiere Physicians Express Urgent Care

PATIENT INTAKE FORM

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Cell: _____

Social Security #: _____ E-mail: _____

Gender: ☐ Female ☐ Male Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Employment: ☐ Retired ☐ Employed ☐ Unemployed ☐ Disabled

Employer: _____ Work phone: _____ Ext:_____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Telephone: _____

I GIVE PERMISSION TO DISCUSS MEDICAL INFORMATION WITH THE FOLLOWING PERSON(S):

Name: _____ Relationship: _____ Telephone: _____

HOW DID YOU HEAR ABOUT US?

☐ Flyer/Magnet (In the Mail) ☐ Website/Internet ☐ Building Sign ☐ Friend/Family/Business Referral ☐ Sign Holder

PRIMARY INSURANCE

Insurance Company: _____

ID#: _____ Group#: _____

Policyholder Name: _____ DOB of Policyholder:_____

Relationship to Policyholder: _____ SSN# of Policyholder:_____

SECONDARY INSURANCE

Insurance Company: _____

ID#: _____ Group#: _____

Policyholder Name: _____ DOB of Policyholder: _____

Relationship to Policyholder: _____ SSN# of Policyholder:_____

AUTHORIZATION AND RELEASE

Authorization for treatment: I voluntarily consent to the administration and cost of medical and surgical procedures, x-ray, and medication for myself and my dependents.

Release of records: I authorize Express Urgent Care to release (verbal or in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or other health care operations which may be liable to me or my practitioner(s) for charges for this treatment and for quality management, utilization review, transfer, and follow-up purposes.

Print Name: _____ Signature: _____ Date: _____

Patient Name: _____ DOB: _____ Date: _____

Reason for today's visit: _____

Name of your Primary Care Physician: _____Phone: _____

Are you experiencing any following**? IF "YES", PLEASE STOP AND NOTIFY STAFF IMMEDIATELY**.

- SEVERE Chest Pain
- SEVERE Shortness of breath
- Uncontrolled bleeding
- Allergic reactions
- Any other life-threatening condition

Are you allergic to any medications: ☐ YES ☐ NO If yes please list: _____

Are you Pregnant: ☐ YES ☐ NO ☐ MAYBE Date of last menstrual cycle: _____

SOCIAL HISTORY

	YES	NO	
Do you smoke or chew tobacco?			**How Often**
Do you drink alcoholic beverages?			**How Often**
Are you using illicit drugs?			**Type:**

Please list all medications you are currently taking **INCLUDING** over the counter medications:

MEDICATIONS / DOSAGE	MEDICATIONS / DOSAGE

Pharmacy Preference:_____ Location: _____

PAST MEDICAL HISTORY

Have you ever had or do you now have any of the following:

Illness	Yes	No	Illness	Yes	No	Illness	Yes	No
High Blood Pressure			Diabetes: ☐ 1 or ☐ 2			Seizure		
Heart Attack			GI Bleed			Renal Failure		
Asthma / COPD			Thyroid Disease			Liver Disease		
Atrial Fibrillation			GERD/ Acid Reflux			Hepatitis ☐ B or ☐C		
High Cholesterol			Stroke / TIA's			HIV		
Congestive Heart Failure			PVD/PE/DVT (Clots)			Chronic Pain		

PAST SURGICAL HISTORY

Please list any past surgeries: _____

Please indicate any other past or present history not listed above:

Notice of Privacy

***To Our Patients*:** This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

- Express Urgent Care is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.
- We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests
2. You can request a restriction of disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing.
4. You may ask to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing.
5. Right to copy this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Administrator. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

I hereby acknowledge that I have been presented with a copy of Notice of Privacy

Print Name: _____ Signature: _____ Date: _____

Important Information for our Insurance Patients

Staff: Retain original for patient file; provide copy to patient

Payment is required for each visit including follow-up and re-checks.

Since you are using your insurance, we believe that it is important to communicate some important information regarding the financial obligations of your visit today. To make your visit more convenient, **we will attempt to obtain an estimate of your insurance benefits** from your insurance carrier at the time of service in order to determine your payment today. Since today's benefits are a "quote" we will collect and file to your insurance accordingly and then wait for the insurance company to process your claim. Your insurance will then determine if you are eligible for reimbursement or if you have any further responsibility and we will then collect any balance due as indicated on your insurance company's Explanation of Benefits (EOB). We will both receive this EOB in the mail – if any 'patient responsibility' amounts are indicated, we will bill you for these additional amounts. We will also write-off the entire discount that your insurance company indicates.

If we are unable to obtain an estimate of your insurance benefits you may be required to pay more than your co-pay. If you have a deductible type plan you may be required to pay in full. Deductibles vary and depend on your specific plan type. Insurance doesn't pay anything until your deductible is met. You may be eligible for a refund because your **deductible was met** and the 'patient responsibility' indicated on the EOB was less than the amount you paid. We will promptly refund you if this occurs. If the insurance EOB indicates you owe more, we will bill you for these services and by signing below you agree to pay for these services when you receive our statement.

Copay/Deductible/Coinsurance $_____

Today, we will collect the copay/deductible/coinsurance as direct by your insurance company or as determined based on your ID card and insurance plan type. You may owe more after your claim is processed and the EOB is received. Sometimes copays don't cover certain services such as laboratory test, strep screens, immunizations, x-rays, injectable medicines/antibiotics, orthopedic supplies, surgical procedures and other services. It depends on your specific plan type. If the insurance EOB indicates you owe more, we will bill you for these services and by signing below you agree to pay for these services when you receive your statement.

I request that payment of authorized Medicare benefits, or any other insurance benefits be made to either me or on my behalf to Express Urgent Care for any services furnished to me. I authorize any holder of medical information concerning me to be released to my insurance carrier or Health Care Financing, its agents; any information needed to determine these benefits or the benefits payable for related services. A photocopy of this authorization shall be considered effective and valid as the original. **I understand that I am financially responsible for all charges not covered by my insurance company.**

I have read and been given a copy of this letter and understand that I may owe Express Urgent Care more than what I have paid today. Upon receipt of my insurance company's Explanation of Benefits (EOB), Express Urgent Care will bill me for any additional indicated and I agree to pay these amounts upon receipt of the statement.

Late payment may be referred to a collection agency, and the collection agency fee will be added to the outstanding balance. The agency fee is 30% of the outstanding balance.

Print Name: _____ Signature: _____ Date: _____