

ADULT - 18+ over

ROBERTSDALE URGENT CARE

PATIENT INFORMATION:

NAME _____ DOB _____
SSN: _____ SEX: M F MARITAL STATUS: S M D W
Mailing ADDRESS _____
CITY _____ STATE _____ ZIP _____
PHONE #'S: HOME _____ CELL _____ WORK _____
EMAIL ADDRESS _____
PREFERRED PHONE #: H C W

EMPLOYER INFORMATION:

NAME _____ PHONE# _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____

RACE:

- ASIAN
- BLACK OR AFRICAN AMERICAN
- HISPANIC/LATINO
- AMERICAN INDIAN
- NATIVE HAWIAN
- WHITE
- OTHER

LANGUAGE:

- ENGLISH
- FRENCH
- ITALIAN
- SPANISH
- VIETNAMESE
- CHINESE
- OTHER

RESPONSIBLE PARTY: IF SELF PLEASE SKIP

NAME _____ DOB _____
SSN: _____ SEX: M F MARITAL STATUS: S M D W
RELATION TO PATIENT _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
PHONE #'S: HOME _____ CELL _____ WORK _____

INSURANCE:

INSURED/SPONSOR NAME _____ RELATION _____
DOB OF SPONSOR _____

EMERGENCY CONTACT:

NAME _____ RELATION TO PATIENT _____
PHONE # _____

Medical History

Date: _____

Personal			Family	
Yes	No		Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	COPD	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>

Please describe any "Yes" answers:

Lifestyle / Habits

Alcohol Yes No

Caffeine Yes No

Cigarettes Yes No

Cigars Yes No

Coffee Yes No

Exercise Yes No

Illicit Drugs Yes No

Hospitalizations

Hospitalizations Yes No
 Year: _____ Reason: _____

Surgeries Yes No
 Year: _____ Reason: _____

Blood Transfusions Yes No
 Year: _____ Reason: _____

Allergies

Are you allergic to any medications? Yes No

If so please list the drug:

Do you have any non-drug allergies? Yes No

If so please list the allergy:

PRIMARY CARE PHYSICIAN:

SPECIALISTS:

PREFERRED PHARMACY:

Colonoscopy Yes No Year _____

Hemocult Yes No Year _____

Mammography Yes No Year _____

Pap Smear Yes No Year _____

PSA Yes No Year _____

DEXA Yes No Year _____

Eye Exam Yes No Year _____

L.M.P. _____

Immunizations

Childhood Yes No Year _____

Influenza Yes No Year _____

Pneumovax Yes No Year _____

Tetanus Yes No Year _____

Other: _____

FOR PROVIDER USE ONLY

BP:	RR:
HR:	HT:
TEMP:	WT:
PAIN:	SPO2:

Is there any other pertinent health information that you would like to list not otherwise noted above? Yes No

If yes, please list:

Do you have any religious limitations concerning your health? Yes No

If yes, please list:

Patient Name: _____ Date of Birth: _____ M / F

MEDICATION LIST

Date: _____

PATIENT: _____ DOB: _____

Please list ALL medications including Vitamins, herbs, over the counter, and supplements.

**IMPORTANT: PLEASE MAKE SURE TO LIST DOSAGE AMOUNT
PLEASE PRINT CLEARLY**

MEDICATION	DOSAGE	HOW OFTEN	PURPOSE	WHO PRESCRIBED

Allergies to Medications

Medication	What happened?

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse _____

Child(ren) _____

Other _____

Information is not to be released to anyone.

**PLEASE
LIST
NAMES**

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call my home my work my cell Number: _____

If unable to reach me:

you may leave a detailed message

please leave a message asking me to return your call

Signed: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____

AUTHORIZATION AND INSURANCE AGREEMENT

CONSENT FOR TREATMENT:

I hereby grant my authorization and consent for medical treatment and procedures for myself and/or my minor children and certify that no guarantee or assurance has been made as to the results which may be obtained.

AGREEMENT TO PAY FOR SERVICES:

For and in consideration of care and treatment provided to me, I promise to pay Robertsdale Urgent Care all charges for services rendered to or on behalf of me. I understand that if insurance is filled on my behalf by Robertsdale Urgent Care, I am responsible for payment of all "NON-COVERED" expenses by my insurance company. I understand that if I am not filing insurance that I will be responsible for all charges rendered to me or to the patient. I understand that failure to render any amount owed after insurance has paid, may result in my account being assessed delinquent. I agree to pay any and all additional charges that may be incurred by Robertsdale Urgent Care for collection of any unpaid account, bad check, or payment instrument.

LIFETIME AUTHORIZATION (for Medicare patients):

I certify the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize release to any holder of medical or other information about me to the Social Security Administration or its intermediaries who carry any information needed for this or related Medicare claims. I assign the benefits payable for assigned services to the physician or organization who will submit the claim for me, and I request that payment for those claims be made on my behalf. I agree and understand this Medicare certification.

MEDIGAP ASSIGNMENT (for Medicare patients):

I request that payment of authorized Medigap benefits be made on my behalf to Robertsdale Urgent Care for any services provided by them. I authorize any holder of medical information about me to release such information to Robertsdale Urgent Care. I understand that I do not need to provide my supplemental insurer with information concerning the Medicare claim because my signing of this authorization will cause Medicare payment information to cross over automatically. I agree and understand the Medigap authorization.

RELEASE OF MEDICAL INFORMATION:

I hereby authorize Robertsdale Urgent Care to release any information necessary to determine payment liability and to obtain reimbursement on any claim. I hereby request and authorize payment of benefits to be made on my behalf to Robertsdale Urgent Care. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is considered as valid as the original.

***I FULLY UNDERSTAND AND AGREE TO COMPLY WITH THE ABOVE STATEMENTS.

SIGNATURE OF PATIENT _____ DATE _____
SIGNATURE OF WITNESS _____

THERE WILL BE A \$35.00 CHARGE ON ALL RETURNED CHECKS.

THERE IS A \$25 FEE TO FILL OUT ANY INSURANCE OR FMLA FORMS. THIS FEE IS THE RESPONSIBILITY OF THE PATIENT AND NOT THE INSURANCE COMPANY. THIS FEE IS DUE BEFORE ANY FORMS WILL BE RELEASED.

SELF PAY

I have no insurance coverage and understand that I am responsible for payment of services rendered **AT TIME OF SERVICE.**

Patient Signature _____ Date _____

Witness _____

INSURANCE

I hereby authorize the release of any information necessary to process insurance claims and request payment of benefits be made to Robertsdale Urgent Care for services rendered.

I understand I am responsible **AT TIME OF SERVICE** for paying any required co-pays or deductibles.

I understand that if I fail to pay amounts owed that an outside collection agency and/or attorney will be utilized to collect the unpaid debt and will report the unpaid debt to a credit-reporting agency. I further understand that I will be responsible for any additional charges or fees, up to 33.3%, as charged by the collection agency plus any reasonable attorney's fees.

Patient Signature _____ Date _____

Witness _____

NOTICE OF PRIVACY PRACTICES

HIPAA, which stands for the Health Insurance Portability and Accountability Act of 1996, is a set of rules to be followed by doctors, hospitals, and other health care providers. HIPAA took effect in April 2006. HIPAA helps ensure that all medical records, medical billing, and patient accounts meet certain consistent standards with regard to documentation, handling, and privacy.

The HIPAA Privacy Rule mandates the protection and privacy of all health information. This rule specifically defines the authorized uses and disclosures of "individually-identifiable" health information.

As our patient, we want you to know that we respect the privacy of your personal medical information and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your healthcare information in order to provide healthcare that is in your best interest. You are entitled to access your personal medical records. In order to receive these records you must sign a HIPAA compliant records release form. We may have indirect treatment relationships with you and may have to disclose personal health information for purposes of treatment, payment, or healthcare operations. These entities are most often not required to obtain patient consent.

By listing your primary care physician and any specialists, you authorize us to send them any records to help keep them up to date on your medical history.

By signing below, I acknowledge that I have reviewed the above HIPAA / privacy practices and how the facility may use and disclose my protected health information. I understand that I may revoke this consent, but must do so in writing. I understand that Robertsdale Urgent Care has the right to refuse to treat me should I choose to refuse disclosure of my PHI (personal health information).

I give permission for Robertsdale Urgent Care to access my pharmacy data electronically. This will allow the provider access to medication history.


YES _____ NO _____

Patient Signature _____ Date _____

Witness _____

ROBERTSDALE URGENT CARE
18557 HAMMOND ST.
ROBERTSDALE AL, 36567
P- 251-947-3591 F-251-947-3593

RELEASE OF MEDICAL RECORDS

 PATIENT'S NAME _____ DOB _____
ADDRESS _____ SSN _____
PHONE # _____

I HEREBY AUTHORIZE:

DR./FACILITY _____
ADDRESS _____
PHONE# _____ FAX _____

TO RELEASE RECORDS TO THE FOLLOWING:

FACILITY _____ ROBERTSDALE URGENT CARE
ADDRESS _____ 18557 HAMMOND ST. ROBERTSDALE AL, 36567
PHONE# _____ 251-947-3591 FAX _____ 251-947-3593

HEALTH INFORMATION THAT MAY BE USED/DISCLOSED:

DISCHARGE SUMMARY HISTORY & PHYSICAL CONSULTATIONS
 PATHOLOGY REPORT OPERATIVE NOTES IMAGING/X-RAY
 PROGRESS NOTES MEDICATIONS LAB
 OTHER (specify) _____ ENTIRE RECORD

INFORMATION IS NEEDED FROM DATES _____

PURPOSE OF DISCLOSURE OF MEDICAL RECORDS:

TREATMENT/CONSULTATION AT REQUEST OF PATIENT BILLING OR CLAIMS
 CONTINUITY OF CARE OTHER (specify) _____

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. This consent will **expire 1 year** from the date on which it is signed. Any disclosure of medical record information by the recipient(s) is not authorized except when implicit in the purpose of the disclosure.

 PATIENT SIGNATURE _____ DATE _____