ROBERTSDALE URGENT CARE

PATIENT INFORMATION:

NAME_______________________ DOB_______________________

SSN: ___________________ SEX: M F MARITAL STATUS: S M D W

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 Yes	Personal No		Family Yes	Family No
☐	☐	Asthma	☐	☐
☐	☐	Arthritis	☐	☐
☐	☐	COPD	☐	☐
☐	☐	Diabetes	☐	☐
☐	☐	Heartburn	☐	☐
☐	☐	Heart Disease	☐	☐
☐	☐	High Cholesterol	☐	☐
☐	☐	High Blood Pressure	☐	☐
☐	☐	Mental Illness	☐	☐
☐	☐	Stroke	☐	☐
☐	☐	Seizures	☐	☐
☐	☐	Cancer	☐	☐

Please describe any "Yes" answers:

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 ____

LMP ________

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

If yes, please list:

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:

Immunizations

Childhood ☐Yes ☐ No Year____

Influenza ☐Yes ☐ No Year____

Pneumovax ☐Yes ☐ No Year____

Tetanus ☐Yes ☐ No Year____

Other:

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

If yes, please list:

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: ______________

FOR PROVIDER USE ONLY	
BP:	RR:
HR:	HT:
TEMP:	WT:
PAIN:	SPO2:

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______________________________ please list names

[ ] Child(ren)______________________________

[ ] Other______________________________

[ ] Information is not to be released to anyone.

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_________________________ DATE____________________

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).

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______________