Patient Information

WALK-IN PRIMARY & URGENT CARE CENTERS
www.PrimaryUC.com

First Name | Middle | Last Name | Date of Birth

Address

City | State | Zip

Sex: M ☐ F ☐

Social Security Number

Cell Phone | Home Phone

Email

Employer or Parent Occupation | Work Phone

Emergency Contact | Relationship

Emergency Contact Address

Emergency Contact Phone | Emergency Contact Email

PRIMARY REASON FOR TODAY'S VISIT

IS THIS RELATED TO:

☐ **WORK INJURY/ACCIDENT?** ☐ **MOTOR VEHICLE ACCIDENT?**

☐ **URGENT CARE** ☐ **PRIMARY CARE**

RESPONSIBLE PARTY/GUARANTOR

First Name | Last Name | M

Social Security Number | Date of Birth

Relationship to Patient

Address

City

State | Zip

Email

Phone

INSURANCE

☐ Self Pay/No Insurance ☐ Using Insurance

Insurance Company

Insurance ID

Patient's relationship to insured:
☐ Self ☐ Spouse ☐ Dependent

Please present your insurance card to the receptionist.

MEDICAL HISTORY

	FATHER	MOTHER	SIBLINGS	CHILDREN
HEART DISEASE	☐	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	☐
STROKE	☐	☐	☐	☐
CANCER	☐	☐	☐	☐
GLAUCOMA	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐
THYROID DISEASE	☐	☐	☐	☐
EPILEPSY/CONVULSIONS	☐	☐	☐	☐

	FATHER	MOTHER	SIBLINGS	CHILDREN
MIGRAINE	☐	☐	☐	☐
MENTAL ILLNESS	☐	☐	☐	☐
ASTHMA/COPD	☐	☐	☐	☐
BLEEDING DISORDER	☐	☐	☐	☐
ANEMIA	☐	☐	☐	☐
OSTEOPOROSIS/ARTHRITIS	☐	☐	☐	☐
KIDNEY DISEASE	☐	☐	☐	☐
ALCOHOLISM/LIVER DISEASE	☐	☐	☐	☐

Patient Disclosures

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AUTHORIZATION FOR DISCLOSURE AND RELEASE TO YOUR PRIMARY CARE PROVIDER

I hereby authorize Walk-In Primary & Urgent Care Centers to automatically disclose and release the medical records from my visit with Walk-In Primary & Urgent Care Centers to my designated primary care provider. I understand that I may get a copy of this form after I sign it. I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time; provided, however, that if I revoke this authorization, I understand that it will not have any effect on actions that Walk-In Primary & Urgent Care Centers and the above-described recipient(s) already took. If I do not revoke this authorization, it will expire six (6) years from my last visit with Walk-In Primary & Urgent Care Centers. This authorization may be revoked at any time by notifying Walk-In Primary & Urgent Care Centers' Privacy Office in writing.

HIPAA PRIVACY AND RELEASE OF INFORMATION AUTHORIZATION

I understand that the information described, or some portion thereof, is protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I understand that by signing this authorization form, I authorize the disclosure and use of my protected health information as described above, and that this information may ultimately be re-disclosed if the recipient(s) described on this form are not required by law to protect the privacy of the information. I understand that signing this authorization is voluntary. My healthcare treatment and benefits (including payment rights and eligibility, as applicable) will not be affected if I do not sign this form. I understand that I may refuse to authorize the automatic release of any personal or health information as described herein and that my refusal to sign and thereby consent to this release will prevent the automatic disclosure of such information for such purposes until Walk-In Primary & Urgent Care Centers receives a request for a release by me or my primary care physician or other provider, but will not affect the health care services I presently receive, or will receive, from Walk-In Primary & Urgent Care Centers.

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGMENT

A Notice of Privacy Practices (NPP) is provided to all patients. This NPP identifies: 1) How medical information may be used or disclosed; 2) Your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our use and disclosures of that information; 3) Your rights to complain if you believe your privacy rights have been violated; and 4) Our responsibilities for maintaining your privacy as your medical representative. I have been offered and have read a copy of the facility's Notice of Privacy Practices, Patient Rights and Responsibilities, and the Patient Payment Policy.

I certify that I have read Walk-In Primary & Urgent Care Centers' Notice of Privacy Practices and the above Authorization and fully understand its terms.

Authorized Signature of Patient / Guardian / Accompanying Adult | Print Name | Date

By signing above, I hereby attest that I am the patient or am otherwise the patient's personal representative legally authorized to make healthcare decisions on his/her behalf.

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VERIFICATION OF INFORMATION

I verify that the above information provided is true and correct to the best of my knowledge. I hereby authorize Walk-In Primary & Urgent Care Centers to accept assignment of insurance benefits and I understand that I am responsible for coinsurance, co-payments, and/or deductibles at the time of service. I understand that if my insurance is a non-contracted plan (out of network); Walk-In Primary & Urgent Care Centers will courtesy file the claim for services rendered. If the claim is denied and/or out-of-network, it is my responsibility to pay the balance on my account. If I have no insurance coverage, I understand that the fees are due at the time of service. As part of my treatment it may be necessary to prescribe Durable Medical Equipment (DME). Walk-In Primary & Urgent Care Centers will make every effort to authorize this service (if needed) with my insurance company. If my insurance company denies this item, or I do not have DME benefits, I will be responsible for any balances. Durable Medical Equipment is nonrefundable and may not be returned.

CONSENT FOR TREATMENT

I hereby consent to medical evaluation, testing, and/or treatment provided to me by staff of Walk-In Primary & Urgent Care Centers which may also include medical and minor surgical treatment or procedures, emergency treatment, and laboratory procedures. I understand that Walk-In Primary & Urgent Care Centers may use or disclose Protected Health Information (PHI) necessary to carry out treatment, payment, or healthcare operations. I authorize release of any information concerning me or my child's healthcare, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize the facility to e-prescribe my prescriptions. For treatment purposes, Walk-In Primary & Urgent Care Centers may request and utilize my medication history from other health care providers or third party pharmacy benefit payers. I acknowledge that if the provider has ordered additional laboratory testing that the collected specimens will be sent to a local laboratory for testing. Walk-In Primary & Urgent Care Centers will forward your payer information to the laboratory but you will be responsible for the charges incurred for these services and will receive a separate bill from the laboratory. I understand that there may be a portion of the cost of Durable Medical Equipment that is not covered by my insurance and I will be responsible for the balance. Please notify staff of any barrier to effective communication or educational instruction that would prevent the understanding of information about the patient's health status, treatment, or the informed decision making process, such as foreign language, hearing or speech impairment, difficulty with reading or writing, or inability to comprehend verbal instruction.

I hereby acknowledge to have read and understood all paragraphs ("Verification of Information" and "Consent for Treatment") and hereby consent to all terms and conditions:

Authorized Signature of Patient / Guardian / Accompanying Adult | Print Name | Date

By signing above, I hereby attest that I am the patient or am otherwise the patient's personal representative legally authorized to make healthcare decisions on his/her behalf.