



Patient Information

Name: _____ **Date of Birth:** _____ **Sex:** Male Female

Address: _____
Street City, State Zip

Home Phone: (____) _____ **Work:** (____) _____ **Mobile:** (____) _____

*A confidential message may be left on your telephone answering machine, voice mail, or email.

**We do utilize texting to send reminders and follow up information.

Email address: _____ **Race:** Asian Black Hispanic White Other

Marital Status: Married Single

Emergency Contact – Name: _____

Relationship: _____ **Phone:** (____) _____

Subscriber for Insurance: Self Spouse Parent **Name and Date of Birth:** _____

Name: _____ **Date of Birth:** _____ **Sex:** Male Female

Social Security #: _____

Address: _____
Street City, State Zip

Home Phone: (____) _____ **Work:** (____) _____ **Mobile:** (____) _____

Worker's Comp

Employer (Worker's Comp): _____ **Phone:** _____

Employer Address: _____
Street City, State Zip

Visit Reason

Illness **Injury** **Physical** **Drug Screen** **Other**

Condition is related to: Work Auto Sports Other None

Today's Problem/Injury: _____

Date of injury/onset of condition: _____ **If Injury, Body Part:** _____ **Left or Right?**

Primary Care Physician: _____

Preferred Pharmacy & Location: _____

Medical History Questionnaire

ALLERGIES:(including latex, drug, food, seasonal) _____

MEDICATIONS: List all that you are currently taking, either prescription or non- prescription. Please specify dosage and length of time taking medication:

Medication	Dosage	How frequently?

Do you use tobacco products? Yes No **If yes, what kind and how many?** _____

Do you drink alcoholic beverages? Yes No **If yes, how many drinks per week?** _____

Are you pregnant? Yes No **If yes, how many weeks?** _____

Mother's Medical History:

Father's Medical History:

Brother's Medical History:

Sister's Medical History:

Patient Medical History: Have you ever been diagnosed as having any of the following conditions?

Yes	No		Yes	No	
		Cancer			Infectious Disease
		Chest Pain or Shortness of Breath			Hepatitis
		Heart Disease or Arrhythmia			Headaches Frequent/Severe
		High Blood Pressure			Hearing/Vision Difficulties
		Pacemaker			Numbness or Tingling
		Heart Attack			Dizziness
		Stroke or TIA			Weakness
		Congestive Heart Disease			HIV/AIDS
		Blood Clots			Mental Health
		Circulation Problems			
		Seizure Disorder or Epilepsy	If yes, please explain:		
		Thyroid Problems			
		Asthma or Emphysema			
		Chemical Dependency			
		Diabetes			
		Rheumatoid Arthritis			
		Other Arthritis Conditions			
		Fibromyalgia			

Surgery: List Type and Date _____

Consent for Treatment

- I hereby consent to medical evaluations, testing, and/or treatment provided by the staff of Urgent Care of Oconee. I understand the benefits, risk, and possible side effects of receiving medications and vaccines and that it is my responsibility to provide any information relevant to health history, possible medication interactions and allergies.
- I understand that if the provider has ordered additional laboratory test that the collected specimens may be sent to a local laboratory for testing. Urgent Care of Oconee will forward my payer information to the laboratory, but I 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 company and I will be responsible for the balance.
- I understand that Urgent Care of Oconee may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.
- I understand that Urgent Care of Oconee utilizes Physician Assistants.

Financial Policy

Insurance Plans and Policies

- We participate with most insurance plans.
- It is your responsibility to check with your insurance plan prior to your visit to make sure we are in network and a participating provider.
- **Knowing your insurance benefits is your responsibility.**

Proof of Insurance

- A copy of a valid insurance card will be needed on the day of your appointment.
- It is your responsibility to provide our office with this information. If you do not have a copy of your card, you will be considered a self-pay patient.

Co-payments and Billing Statements (Please check)

- Co-payments are due at the time of your visit.
- All co-payments and deductibles are based upon Primary Insurance coverage.
- Please remember that we are contractually obligated by your insurance company to collect co-payments and deductibles.
- We will file your charges with your insurance company. You will be responsible for payment of any remaining balance.

120 Days Collection Balances: Please Initial _____

- If your account has a balance after 120 days and no payment plan has been made, your account will be sent to a **collection agency**.
- If your account is sent to a collection agency, a **25% fee** will be added to your balance.

Cash, Check, or Credit Cards (Visa, Mastercard, Discover, or AMEX)

- Returned checks are subject to a \$30.00 fee.

Failure to receive your statement does not relieve you from your financial obligation. It is the patient's responsibility to notify our office with any address or contact changes.

Patient (or Guardian) Signature: _____ Date: _____

Print Name: _____

HIPAA Patient Consent Form

This consent form goes over the Health Insurance Portability & Accountability Act of 1996. HIPAA provides information about how we may use and disclose protected health information about you. This Notice contains a Patient’s Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may be subject to change at any given point. If we change our Notice, you may obtain a revised copy by contacting our office or going to our Website at urgentcareofoconee.com.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, health care operations, and/or coordination of care.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, health care operations, and coordination of care. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient understands that:

- ✓ Protected health information may be disclosed or used for treatment, payment, health care operations, and/or coordination of care.
- ✓ The patient has the right to obtain and view the Notice of Privacy Practices containing a more complete description.
- ✓ The Practice reserves the right to change the Notice of Privacy Policies.
- ✓ The patient has the right to look over and/or obtain a copy of their health care records with a signed release.
- ✓ The patient has the right to restrict the uses of their information.
- ✓ The patient may provide a written request to revoke this consent at any time during care.
- ✓ If the patient refuses to sign the consent form for purposes of treatment, payment, health care operations, and/or coordination of care, the Practice has the right to refuse care to the patient.

Patient (or Guardian) Signature: _____ Date: _____

Patient’s Name: _____ Date of Birth _____

Optional:

Patient gives permission to Urgent Care of Oconee to verbally discuss the following with the individuals below.

Please check:

- Scheduling and Appointment Information
- Medical Information: including my symptoms, diagnosis, medications, treatment plan.
- Lab Results
- Billing and Payment Information
- Other: _____

Name	Relationship	Contact Number
_____	_____	_____
_____	_____	_____