URGENT CARE OF OCONEE

Patient Information

Demographics:

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.

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

Marital Status: □ Married □ Single

Employer (Worker's Comp):_____

Employer Address:_____
Street *City, State* *Zip*

Emergency Contact – Name:_____

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

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

Responsible Party (if patient is a minor):

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

Social Security #: _____

Address:_____
Street *City, State* *Zip*

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

Visit Reason:

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

Condition is related to: □ Work □ Auto □ Home □ 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:_____

Please Initial Page ☐

2061 Experiment Station Rd., Suite 505
Watkinsville, GA 30677

706.310.0324 Office
706.310.0320 Fax

urgentcareofoconee.com
urgentcareofoconee@gmail.com

URGENT CARE OF OCONEE

Medical History Questionnaire

Name: _____ **Date:** _____

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_____

_____

_____

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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

- 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.
- If your account has a balance after 120 days and no payment plan has been made, your account may be sent to a collection agency.

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:_____

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OF OCONEE

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:

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

Name	Relationship	Contact Number
_____	_____	_____
_____	_____	_____