THE URGENT CARE WALK-IN CLINIC

CHECK IN WORKSHEET

WE ARE NOT AN EMERGENCY FACILITY

Name: _____, _____
Last **First**

Date of Birth: _____/_____/_____ Phone Number: _____ SSN: _____-_____-_____

Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip Code: _____

What is the reason for your visit? _____
(Examples: Cough, Ear Infection, Fever, Flu, Rash, Sinus Infection, Urinary, etc.)

Are you here due to injuries from a car accident?	*Yes*	*No*
Are you here due to injuries related to work?	*Yes*	*No*
Would you like a flu vaccine today?	*Yes*	*No*
Do you need a doctor's note for school or work?	*Yes*	*No*

Preferred Pharmacy: _____ Cross Streets/Address: _____

Primary Insurance: _____ Secondary Insurance: _____

How would you like us to educate you on your diagnosis? *(Circle all that apply)*

Paper Handouts *Visual Communication* *Verbal Communication*

If you do not want to receive a call back after your visit, please check here. ☐

HIPAA Patient Consent

By signing below, I have read and fully understand the Patient Consent for Use and Disclosure of Protected Health Information, revised July 2016. I consent and agree to all of its terms and conditions. I understand copies of The Urgent Care's full Notice of Privacy Practices are available for me at my request.

Patient Responsibility and Financial Policy Clause

By signing below, I have read and fully understand The Urgent Care's Patient Responsibility and Financial Policy. I accept and agree to all of its terms and conditions. Specifically, I understand that I am responsible for any medical treatment and medical equipment not covered by my insurance plan or applied towards my copay, coinsurance, and/or deductible. I understand that balances may be assessed interest and collection fees. I understand that any overpayments may remain as a credit balance on my account, to be applied to future charges, unless I request a refund. Credit balances remaining will be handled per the Patient Responsibility and Financial Policy may be assessed inactivity fees and/or processing fees if sent to the Louisiana Secretary of State LSA R.S. 9:151 et seq.

Consent for Treatment

By signing below, I understand that I have a choice to be seen at The Urgent Care versus the hospital Emergency Department, my primary care, or a specialist. I authorize The Urgent Care to provide medical treatment and services to me. I understand I am authorizing The Urgent Care to treat me while I seek care from The Urgent Care or until I withdraw my authorization in writing.

Signature: _____ Date: _____/_____/_____