PATIENT CHECK IN WORKSHEET

First Name: _____ **Middle:** _____ **Last:** _____

Date of Birth: _____/_____/_____ **SSN:** _____-_____-_____ **Sex**: Male / Female

Home #: (_____)_____-_____ **Cell #:** (_____)_____-_____ **Email:**_____

Address: _____**Apt/Suite:** _____ **City:** _____**State:** _____ **Zip Code:** _____

Emergency Contact: _____ **Phone #:** (_____)_____-_____ **Relationship:** _____

Reason for your visit: _____

(Examples include: Cough, Ear Infection, Fever, Flu, Rash, Sinus Infection, injury, Urinary, etc.)

Are you here due to injuries from a car accident or work injury? Yes No
Do you need a doctor's note for school or work? Yes No
Do you need a paper copy of your discharge summary? Yes No

List All Medical Insurance(s): _____

Preferred Pharmacy: _____ **Address/ Cross Streets:** _____

*If you **DO NOT** wish to receive a follow up call, check here* ☐

ADDITIONAL INFORMATION

How did you hear about us? Friend/Family Drive-by Yelp Facebook Google Military Dir. Ins. Dir. Dr. Referral Phonebook

Race: American Indian/Alaska Native Asian Black/African American Native Hawaiian/Pacific Islander White *Patient Declines*

Ethnicity: Hispanic or Latino Not Hispanic or Latino *Patient Declines*

Preferred Language: English Spanish Vietnamese Other _____ *Patient Declines*

PARENT/ LEGAL GUARDIAN IS NOT PRESENT CONSENT

The patient's legal guardian *(full name)* _____ verbally authorizes The Urgent Care to treat *(minor patient's name)* _____ *(relation)* _____. Legal guardian phone #: (_____)_____-_____

GUARANTOR*(PERSON FINANCIALLY RESPONSIBLE FOR MINOR)*

Name: _____DOB: _____Relation:_____

Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip Code: _____

AUTHORIZATION & AGREEMENT

HIPAA Patient Consent

By signing below, I have read and fully understand the Patient Consent for Use and Disclosure of Protected Health Information, rev. 7/ 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 on 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. These services include, but are not limited to: Injections (administration fee & medicine), IV treatments and fluids (initial IV treatment, hydration, medicine, etc.), and durable medical goods (crutches, walking boots, splints, slings, ace wraps, etc.) 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.

Patient Signature: _____ **Date:** _____/_____/_____

I declare the above information is true. I authorize my insurance benefits to be paid to The Urgent Care. I understand that I am financially responsible for any charges that may not be covered by my insurance plan. I authorize my medical information to be released to my insurance company/ any of its affiliates for medical purposes.