Pediatric - under 18

ROBERTSDALE URGENT CARE

PATIENT INFORMATION:

NAME_____ DOB_____

SSN: _____ SEX: M F MARITAL STATUS: S M D W

MAILING ADDRESS_____

CITY_____ STATE_____ ZIP_____

PHONE #'S: HOME_____ CELL_____ WORK_____

EMAIL ADDRESS_____

PREFERRED PHONE #: H C W

EMPLOYER INFORMATION:

NAME_____ PHONE#_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

RACE:

- ❑ ASIAN
- ❑ BLACK OR AFRICAN AMERICAN
- ❑ HISPANIC/LATINO
- ❑ AMERICAN INDIAN
- ❑ NATIVE HAWIAN
- ❑ WHITE
- ❑ OTHER

LANGUAGE:

- ❑ ENGLISH
- ❑ FRENCH
- ❑ ITALIAN
- ❑ SPANISH
- ❑ VIETNAMESE
- ❑ CHINESE
- ❑ OTHER

RESPONSIBLE PARTY: IF SELF PLEASE SKIP

NAME_____ DOB_____

SSN: _____ SEX: M F MARITAL STATUS: S M D W

RELATION TO PATIENT_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

PHONE #'S: HOME_____ CELL_____ WORK_____

INSURANCE:

INSURED/SPONSOR NAME_____ RELATION_____

DOB OF SPONSOR_____

EMERGENCY CONTACT:

NAME_____ RELATION TO PATIENT_____

PHONE #_____

FOR PHYSICIAN'S USE ONLY:

BP _____ SPO2 _____
HR _____ RR _____
TEMP _____ HT _____
PAIN _____ WT _____

MEDICAL & MEDICATION HISTORY
PLEASE LIST ALL

NAME_____
DOB_____
AGE_____

ALLERGIES

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ALL MEDICATIONS
INCLUDE PRESCRIPTIONS & OTC

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MEDICAL CONDITIONS
SURGICAL HISTORY —

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UP TO DATE ON CHILDHOOD VACCINES: YES NO

PRIMARY CARE PHYSICIAN_____

SPECIALISTS _____
_____
_____

PREFERRED PHARMACY_____

AUTHORIZATION AND INSURANCE AGREEMENT

CONSENT FOR TREATMENT:

I hereby grant my authorization and consent for medical treatment and procedures for myself and/or my minor children and certify that no guarantee or assurance has been made as to the results which may be obtained.

AGREEMENT TO PAY FOR SERVICES:

For and in consideration of care and treatment provided to me, I promise to pay Robertsdale Urgent Care all charges for services rendered to or on behalf of me. I understand that if insurance is filled on my behalf by Robertsdale Urgent Care, I am responsible for payment of all "NON-COVERED" expenses by my insurance company. I understand that if I am not filing insurance that I will be responsible for all charges rendered to me or to the patient. I understand that failure to render any amount owed after insurance has paid. may result in my account being assessed delinquent. I agree to pay any and all additional charges that may be incurred by Robertsdale Urgent Care for collection of any unpaid account, bad check, or payment instrument.

LIFETIME AUTHORIZATION (for Medicare patients):

I certify the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize release to any holder of medical or other information about me to the Social Security Administration or its intermediaries who carry any information needed for this or related Medicare claims. I assign the benefits payable for assigned services to the physician or organization who will submit the claim for me, and I request that payment for those claims be made on my behalf. I agree and understand this Medicare certification.

MEDIGAP ASSIGNMENT (for Medicare patients):

I request that payment of authorized Medigap benefits be made on my behalf to Robertsdale Urgent Care for any services provided by them. I authorize any holder of medical information about me to release such information to Robertsdale Urgent Care. I understand that I do not need to provide my supplemental insurer with information concerning the Medicare claim because my signing of this authorization will cause Medicare payment information to cross over automatically. I agree and understand the Medigap authorization.

RELEASE OF MEDICAL INFORMATION:

I hereby authorize Robertsdale Urgent Care to release any information necessary to determine payment liability and to obtain reimbursement on any claim. I hereby request and authorize payment of benefits to be made on my behalf to Robertsdale Urgent Care. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is considered as valid as the original.

***I FULLY UNDERSTAND AND AGREE TO COMPLY WITH THE ABOVE STATEMENTS.

SIGNATURE OF PATIENT_____ DATE_____

SIGNATURE OF WITNESS_____ DATE_____

THERE WILL BE A $35.00 CHARGE ON ALL RETURNED CHECKS.

THERE IS A $25 FEE TO FILL OUT ANY INSURANCE OR FMLA FORMS. THIS FEE IS THE RESPONSIBILITY OF THE PATIENT AND NOT THE INSURANCE COMPANY. THIS FEE IS DUE BEFORE ANY FORMS WILL BE RELEASED.

SELF PAY

I have no insurance coverage and understand that I am responsible for payment of services rendered **AT TIME OF SERVICE.**

Patient Signature_____ Date_____

Witness_____

INSURANCE

I hereby authorize the release of any information necessary to process insurance claims and request payment of benefits be made to Robertsdale Urgent Care for services rendered.

I understand I am responsible **AT TIME OF SERVICE** for paying any required co-pays or deductibles.

I understand that if I fail to pay amounts owed that an outside collection agency and/or attorney will be utilized to collect the unpaid debt and will report the unpaid debt to a credit-reporting agency. I further understand that I will be responsible for any additional charges or fees, up to 33.3%, as charged by the collection agency plus any reasonable attorney's fees.

Patient Signature_____ Date_____

Witness_____

NOTICE OF PRIVACY PRACTICES

HIPAA, which stands for the Health Insurance Portability and Accountability Act of 1996, is a set of rules to be followed by doctors, hospitals, and other health care providers. HIPAA took effect in April 2006. HIPAA helps ensure that all medical records, medical billing, and patient accounts meet certain consistent standards with regard to documentation, handling, and privacy.

The HIPAA Privacy Rule mandates the protection and privacy of all health information. This rule specifically defines the authorized uses and disclosures of "individually-identifiable" health information.

As our patient, we want you to know that we respect the privacy of your personal medical information and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your healthcare information in order to provide healthcare that is in your best interest. You are entitled to access your personal medical records. In order to receive these records you must sign a HIPAA compliant records release form. We may have indirect treatment relationships with you and may have to disclose personal health information for purposes of treatment, payment, or healthcare operations. These entities are most often not required to obtain patient consent.

By listing your primary care physician and any specialists, you authorize us to send them any records to help keep them up to date on your medical history.

By signing below, I acknowledge that I have reviewed the above HIPAA / privacy practices and how the facility may use and disclose my protected health information. I understand that I may revoke this consent, but must do so in writing. I understand that Robertsdale Urgent Care has the right to refuse to treat me should I choose to refuse disclosure of my PHI (personal health information).

I give permission for Robertsdale Urgent Care to access my pharmacy data electronically. This will allow the provider access to medication history.

YES_____ NO_____

Patient Signature_____ Date_____

Witness_____