Pacific Urgent Care & Family Medicine

Patient Information

Patient Name: _____ DOB: _____
Last First MI (MM/DD/YY)

Address: _____
Street Apt #

City: _____ State: _____ Zip Code: _____

Social Security #: _____ Circle One: Male Female Married Single Child

Phone (Home): _____ (Work): _____ (Cell): _____

Email: _____ Occupation: _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Primary Insured Name: _____ Relationship: _____ DOB: _____
Last First (MM/DD/YY)

How did you hear about us? _____

MEDICAL HISTORY: (illnesses, hospitalizations, surgeries)

1. _____

2. _____

3. _____

4. _____

5. _____

Drug Allergies:

1. _____ **Reaction:** _____
2. _____ **Reaction:** _____
3. _____ **Reaction:** _____

Family Medical History: (diabetes, cancer, heart disease, etc.)

_____

Social History:

Smoker Y____ N_____ Past _____ Alcohol _____ Illicit Drugs:_____

Current Medications:

Name	Dosage	How Many Times A day
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____

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CONSENT FOR TREATMENT

I request and authorize Health Care Services by my physician, and his/her designees may deem advisable. This may include routine diagnostic, radiology and laboratory procedures and medication administration.

_____Date: _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENATIVE

PRIVATE INSURANCE, ASSIGNMENT OF MEDICAL BENEFITS

I hereby assign transfer and set over to PACIFIC URGENT CARE & FAMILY MEDICINE all of my rights, title and interest to my medical reimbursement benefits under my insurance policy for any services furnished to me by PACIFIC URGENT CARE & FAMILY MEDICINE. I understand I am financially responsible for any balance not covered by my insurance carrier.

_____ Date: _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENATIVE

MEDICARE, ASSIGNMENT OF MEDICAL BENEFITS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to PACIFIC URGENT CARE & FAMILY MEDICINE for any services furnished me by physician or supplier. I authorize any holder of medical information about me to release to PACIFIC URGENT CARE & FAMILY MEDICINE and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ Date: _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENATIVE

COMMUNICATIONS AUTHORIZATION

PACIFIC URGENT CARE & FAMILY MEDICINE, its physicians and staff, are authorized to use telephone message systems to aid communication with me, or my authorized representative, regarding my treatment, appointments, financial arrangements, and in response to any request I have initiated.

_____ Date: _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENATIVE

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

PACIFIC URGENT CARE & FAMILY MEDICINE, its physicians and staff, are authorized to SHARE INFORMATION and provide copies of my entire medical records, including all written and oral reports, substantive evaluations of progress, history, diagnosis, prognosis, course of treatment, reports, and attendance and compliance with respect to all care or treatment, including all confidential HIV and AIDS related information, mental health records, drug and alcohol, abuse treatment records, sexual assault and sexual abuse counseling records to my insurance companies, doctors, treating facilities, and my employer in the case of Worker's Compensation, AND THE FOLLOWING PERSONS IF DESIRED:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ Date: _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENATIVE

NOTICE OF PRIVACY PRACTICES (HIPAA)

If you did not receive these documents, or have misplaced them, please ask for another copy. This signature page is in reference to the Federal HIPAA Privacy Regulations requirements. The undersigned certifies that he/she has received a copy of the Notice of Privacy Practices (HIPAA), and is the client, or is duly authorized by the client as the client's representative. If a more detailed verbal explanation is needed, in addition to the one you received, please request one now and we would be pleased to assist you.

_____ Date: _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENATIVE

I HAVE READ AND UDERNSTAND THE ABOVE ASSIGNMENTS AND AUTHORIZATIONS TO USE/DISCLOSE HEALTH INFORMATION ABOUT THE NAMED PATIENT AS DESCRIBED. THESE ASSIGNMENTS/AUTHORIZATIONS REMAIN IN AFFECT UNTIL REVOKED BY ME IN WRITING.

A copy of any or all above signatures is as valid as the originals

NAME _____
Last First Middle

CONFIDENTIAL

ALL PATIENTS PLEASE READ

We are contracted with most local PPO insurances and Medicare. If we are not contracted with your insurance, we will provide you with the necessary documents for you to submit the claim for reimbursement according to your benefits.

Copays are due at the time of service. For cash patients, all payments are due at the time of service.
If you have coinsurance, it is our office policy to collect $40 at the time of service that will go toward your responsibility after the insurance company pays its portion.

We accept Monarch Healthcare & Prospect & Gateway & Regal & St. Joseph HMO plans for Urgent Care ONLY. We can see St. Joseph HMO patients for primary care if they designate physician as Primary Care Provider (PCP) & have an appointment during Primary Care Hours.

Lab work and diagnostic services ordered by the physician will be billed separately by the facility.

We don't accept checks. If your account is placed with a collection agency, an additional 25% will be added to the balance. There will be a $30 clerical fee for all retro authorizations.

We utilize the California Department of Justice Bureau of Narcotic Prescription Drug Monitoring Program (CURES) to identify prescription drug dispensing history. Our physicians will not prescribe controlled medications if any controlled medications have been prescribed by physicians outside PACIFIC URGENT CARE & FAMILY MEDICINE on ongoing and regular basis. You will be responsible for all standard office visit charges for the evaluation.

ASSIGNMENT OF INSURNACE BENEFITS AND PAYMENT GUARANTEE

In consideration of services being provided by PACIFIC URGENT CARE & FAMILY MEDICINE, I hereby assign and transfer to PACIFIC URGENT CARE & FAMILY any and all rights, which I have against insurance companies, governmental agencies, or third party payers, for payment of charges for services provided by PACIFIC URGENT CARE & FAMILY to me or my dependents.

I understand that I am responsible for and will pay the portion of my bill not covered by insurance companies, governmental agencies and third party payers. I am authorizing PACIFIC URGENT CARE & FAMILY to process charges on my credit card (s), debit card (s), and/or bank account (s) for the current visit charges, past charges, or for future balances on his visit that are not paid by any third party such as insurance carriers or companies. In consideration of services to be provided, I agree to pay PACIFIC URGENT CARE & FAMILY in accordance with the regular rates and terms of PACIFIC URGENT CARE & FAMILY.

If I receive a billing statement, I further agree to pay the account in full upon receipt and conditions of my billing statement unless other payment arrangements are made first. I authorize said payments to be applied to any unpaid PACIFIC URGENT CARE & FAMILY balance for which I am responsible.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION

_____ _____
Signature Date