Premium URGENT CARE

Pharmacy Name: _____

Pharmacy Location: _____

Date of Service: _____

Location (select one): [ ] Herndon Ave. [ ] Milburn Ave. [ ] Turlock [ ] Los Banos

PATIENT'S INFORMATION

Last Name _____ First Name _____ MI _____ DOB _____

Address _____ Apt# _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Sex: ☐ Male ☐ Female SSN _____

Confidential E-mail Address _____ Home E-mail Address _____

Race/Ethnicity (Please Select One): ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic

☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Other _____

Preferred Language (Please Select One): ☐ English ☐ Spanish ☐ Other _____

Emergency Contact _____ Phone _____ Relationship _____

Who or what may we thank for your referral (Please Select One): ☐ Drive By/Signage ☐ Family or Friend
☐ Physician _____ ☐ Insurance Company ☐ Web Search ☐ Social Media ☐ Mail/email
☐ Radio/TV ☐ Other _____

What is the primary reason for your visit today? _____

Is this visit related to: Work Injury (Circle One): YES NO Motor Vehicle Accident? (Circle One) YES NO

Are you currently participating in any medical research studies? ☐ YES ☐ No If yes, explain: _____

Primary Care Physician _____ Office Phone Number _____

A message requesting a return call may be left on (select): ☐ Cell Phone ☐ Home Phone ☐ None

Other than the patient, who may we speak with in regards to any billing questions concerning your Premium Urgent Care account?

N/A or Name: _____ Phone # _____ DOB

Responsible Party/Guarantor (insurance holder for patients under 18 years of age)

Last Name _____ First Name _____ MI _____ DOB _____

Address _____ City _____ State _____ Zip _____

Phone _____ SSN _____ Relationship to Patient _____

INSURANCE INFORMATION

☐ Self Pay / No insurance

☐ Self Pay / Do not bill insurance

☐ Card Provided

Primary Insurance Company _____ Policy # _____ Group # _____

Subscriber Info. _____ DOB _____ Relationship to Patient _____

☐ Card Provided

Secondary Insurance Company _____ Policy # _____ Group # _____

Subscriber Info. _____ DOB _____ Relationship to Patient _____

CONTINUED ON BACK SIDE

Premium
URGENT CARE

Consent for Treatment

I hereby consent to medical evaluation, testing, and/or treatment provided to me by the staff of this facility which may also include medical and minor surgical treatment or procedures, emergency treatment, and laboratory procedures. I understand that this medical facility may use or disclose Protected Health Information (PHI) necessary to carry out treatment, payment, or healthcare operations. I authorize release of any information concerning me or my child's healthcare, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize the facility to eOprescribe my prescriptions. For treatment purposes, the facility may request and utilize my medication history from other health care providers or third party pharmacy benefit payers. I acknowledge that if the provider has ordered additional laboratory testing that the collected specimens will be sent to a local laboratory for testing. The facility will forward your payer information to the laboratory but you 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 and I will be responsible for the balance. Please notify staff of any barrier to effective communication or educational instruction that would prevent the understanding of information about the patient's health status, treatment, or the informed decision making process, such as foreign language, hearing or speech impairment, difficulty with reading or writing, or inability to comprehend verbal instruction.

_____ _____

Authorized Signature of Patient / Guardian / Accompanying Adult Date

Notice of Privacy Practices (NPP) Acknowledgment

A Notice of Privacy Practices (NPP) is provided to all patients. This NPP identifies: 1) How medical information may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our use and disclosures of that information; 3) Your rights to complain if you believe your privacy rights have been violated; and 4) Our responsibilities for maintaining your privacy as your medical representative.

I have been offered and have read a copy of the facility's Notice of Privacy Practices, Patient Rights and Responsibilities, and the Patient Payment Policy.

_____ _____

Authorized Signature of Patient / Guardian / Accompanying Adult Date

_____ _____

Signature of Witness Date

Verification of Information: I verify that the information provided is true and correct to the best of my knowledge. I hereby authorize the facility to accept assignment of insurance benefits and I understand that I am responsible for coinsurance, co-payments, and/or deductibles at the time of service. I understand that if my insurance is a non-contracted plan (out of network); the facility will courtesy file the claim for services rendered. In the event that I have no insurance coverage, I understand that the fees are due at the time of service. I understand that the previous balances owed to the facility will be requested at the time of registration.

_____ _____

Authorized Signature of Patient / Guardian / Accompanying Adult Date