Preferred UrgentCare

Patient Registration Form

Preferred Urgent Care
1450 W. Grand Parkway South
Suite M
Katy, TX 77494
281.916.1444

Patient Information

Full Name: ____
Last *First* *M.I.*

Date of Birth: ____________________ SSN: ____________________ ☐ Male ☐ Female

Parent/Guardian Name(s)*: ____
If Patient is a minor

Address: ______________________________
____
____
City *State* *ZIP code*

Cell: ____________________
Home: ____________________
Work: ____________________
Email: ____________________

*To gain access to your medical records online, please provide email
☐ Opt- out of newsletters and email updates

☐ **Check if you authorize P.U.C to release all medical records including HIV testing to the PCP listed below: Intials:_____**

Primary Care Doctor: ____________________________________ Phone#:_________________________________

Address: ____ Fax#:__________________________________

Pharmacy Name: ____ Phone:________________________________

Address: ____

How did you find us? ☐**PCP** ☐**Friend** ☐**Family** ☐**Former patient** ☐**Google** ☐**Facebook** ☐**Maps** ☐**Yelp** ☐**Katy Magazine** ☐**Gotta-Run** ☐**Mann Eye** ☐**Insurance** ☐**ER:_____** ☐**School:______** ☐**Pharmacy:______** ☐**Drive-by** ☐**Live nearby** ☐**Other:_______**

Insurance Information

Insurance Company
(Please provide front desk with your insurance card and a valid ID)

☐ No Insurance (Self Pay)

☐ Aetna ☐ Blue Cross Blue Shield ☐ Cigna ☐ Humana ☐ United Healthcare ☐ Medicaid ☐ Medicare

☐Other Insurance: ____

Subscriber/Policyholder Information ☐ Self (skip this section)

Subscriber Name: ____
Last, First, M.I. *Relationship to Patient*

Date of Birth: ____________________ SSN: ____________________ ☐ Male ☐ Female

☐ Address is same as Patient's Address

Address: ______________________________
____
____
City *State* *ZIP code*

Cell: ____________________
Home: ____________________
Work: ____________________
Email: ____________________

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Emergency Contact Information

Emergency Contacts

____
Name *Phone #* *Relationship to Patient*

____
Name *Phone #* *Relationship to Patient*

Confidential Communication Information

I hereby permit the following means of communication related to my personal health, treatment, diagnosis, test results, or billing as noted below:

☐ All of following are acceptable ☐ Phone ☐ Voicemail ☐ Mail ☐ Email

Patient Demographics Information

Marital Status ☐ Single ☐ Married ☐ Divorced ☐Widowed ☐ Separated ☐ Partnered

Ethnicity/Race ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ White/Caucasian
☐ Other__________________________________

Patient Work Information

____
Occupation *Work Name* *Work Phone #*

REASON FOR TODAY'S VISIT

____

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Medical History

____

Name (Last, First, MI) ***Age*** ***Sex***

Allergies (List all allergies and reaction to any medications, foods or agents): ☐ **No Allergies**

____

Medications

List all current medications, prescriptions or over the counter.
Include their names, dosage, and frequency: ☐ **No Medication(s)**

____ ____

____ ____

Medical History

Select all diseases/conditions that you have or had: ☐ **No Medical History**

☐ Anemia ☐ Depression/Anxiety ☐ High Blood Pressure ☐ Seizures/Epilepsy

☐ Arthritis ☐ GI Disorder ☐ Liver Disorder ☐ Sexually Transmitted Disease

☐ DVT/ PE ☐ Heart Disease ☐ Osteoporosis ☐ Thyroid Disorder (Hyperactive/Hypoactive)

☐ Diabetes (I/II) ☐ High Cholesterol ☐ Stroke ☐ Respiratory Disease (Asthma/Bronchitis/COPD)

☐ Cancer _________________________________

☐ Other: ____

Surgical History

List any surgeries you have had and the date (MM/YYYY): ☐ **No Surgical History**

____ ____

____ ____

Family History

Select diseases/conditions that a family has or had. Indicate the relative next to the condition: Mother(**M**) Father(**F**) Paternal Grandmother(**PGM**) Paternal Grandfather(**PGF**) Maternal Grandmother(**MGM**) Maternal Grandfather(**MGF**) Brother(**B**) Sister(**S**): `☐ **Unknown**

`☐ **Unknown/Adopted** ☐ **No Significant Family History**

☐ Anemia ☐ Depression/Anxiety ☐ High Blood Pressure ☐ Seizures/Epilepsy

☐ Arthritis ☐ GI Disorder ☐ Liver Disorder ☐ Sexually Transmitted Disease

☐ DVT/ PE ☐ Heart Disease ☐ Osteoporosis ☐ Thyroid Disorder (Hyperactive/Hypoactive)

☐ Diabetes (I/II) ☐ High Cholesterol ☐ Stroke ☐ Respiratory Disease (Asthma/Bronchitis/COPD)

☐ Cancer_________________________________

☐Other:____

Social History

Alcohol Use: ☐ None ☐ Daily ☐ Occasionally Number of Drinks: ____________ (Daily/Weekly)

Tobacco Use: ☐ Never ☐ Past Use ☐ Presently Cigarettes per Day: ____________ Number of Years: __________

Foreign Travel in the Past Year? ☐ Yes ☐ No Where? ________________________ When? ______________________

Tetanus Shot (Td): ☐ No ☐ Yes ____________ (MM/YY) Flu Shot: ☐ No ☐ Yes ____________ (MM/YY)

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Patient Notice of Privacy Policies

For Use and Disclosure of Protected Health Information (As required by HIPAA)

I hereby give my consent for Preferred Urgent Care to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). Please refer to our Notice of Privacy Policies detailed below for a more complete description of such uses and disclosures.

Preferred Urgent Care's Notice of Privacy Policies has been made available to me and I have the right to a copy if I so desire. Preferred Urgent Care reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Preferred Urgent Care at 1450 W Grand Pkwy South, Suite M, Katy, TX 77494.

I have the right to request that Preferred Urgent Care restrict how it uses or discloses my PHI to carry out TPO. The practices is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

With this consent, Preferred Urgent Care may contact me in reference to any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, insurance items, and laboratory results among others. Preferred Urgent Care may use phone, voicemail, or U.S. mail to contact me regarding such information.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, or later revoke it, Preferred Urgent Care may decline to provide treatment to me.**

Acknowledgement of Receipt of Notice of Privacy Policies

I hereby acknowledge receipt of the Notice of Privacy Practices from Preferred Urgent Care (The covered entity) pursuant to HIPAA and have been advised that full copy of this office's HIPAA Compliance Manual is available upon request. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information. I understand that the practice has reserved a right to change its privacy practices that are described in the notice. I also understand that a copy of any revised notice will be provided to me or made available.

HIPAA Authorization to Disclose

It is the policy of Preferred Urgent Care not to release confidential medical information to patient's family members. We cannot discuss your medical condition, or release diagnostic test results to anyone without your consent. I hereby give consent that my personal health information, treatment, diagnosis, test results, or billing information can be given to the following person(s):

☐ **Check here if you choose the same person(s) as your emergency contact.**

____

Name *Phone #* *Relationship to Patient*

____

Name *Phone #* *Relationship to Patient*

☐ I **do not** authorize the release of my personal health information to any individual(s).

I have read all the provisions listed above and agree to the terms above. Changes to any provision of this agreement will not affect the validity of any other provision in this agreement.

____

Signature of Patient or Authorized Representative *Print Patient's Name* *Date*

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Financial Policy

In order to provide a reasonable quality of healthcare, it is very important for a practice to stay financially viable.

1. Payment is due at the time of service unless arrangements have been made in advance, we accept cash, Visa, Master Card and American Express. We reserve the right to accept checks for our established patients. For returned checks, a fee of $25 will apply.

2. Your Health plan is a contract between you and your Insurance Company. Health plans vary widely as far as benefits are concerned and in some instances your responsibilities may not be evident until we get a response from the insurance company. You will be responsible for Co-pay, Co-insurance, and Deductible and uncovered charges which ever apply to you. The co-pay amount paid at the time of service is only an estimate of the patient's responsibility.

3. We file Insurance claims with the contracted insurance companies. If your insurance Company does not pay the clinic within a reasonable time (30-40 days), we will have to contact you for payment.

4. The services rendered may not be covered by your plan. If the insurance plan determines a service to be "not covered" you will be responsible for the complete charges. If it is later determined that your coverage was not active on the day of the service, you will be responsible for the charges.

5. The billed charges from the clinic will be due within 30 days of the billed date. If you are unable to pay, please call the office to set up a payment plan or an alternate arrangement. If we do not get a response from you after multiple contact attempts, your case may be referred to a collection agency.

6. By signing this disclosure, you authorize payment directly for X-RAY and other ancillary services. You may incur additional charges as a result of these ancillary services. Patient agrees to pay all charges due with respect to such services. Patient(s) acknowledge that X-RAY and other ancillary services are additional charge for which our facility may not be in contract with your insurance carrier. Patient accept responsibility for such X-RAY charges.

Consent for Medical Care and Treatment

I understand that my health condition may require diagnosis and treatment. I hereby voluntarily consent to such treatment, services, and procedures as ordered by my doctor, his consultants, associates and his assistants, or his designee. I also understand student nurses and others in professional training programs may be among the individuals who provide care to me.

I authorize the providers at Preferred Urgent Care and their assistants/designee to discuss my medical history, diagnosis, treatment and prognosis as provided in the notice of privacy practices. I have the right to add anyone or any organization that I do not wish to have my medical information by requesting in writing at any time.

I understand there are times when the law allows the provider and their assistants/designee to release information regardless of whether or not I give my consent as outlined in the notice of privacy practices. For example, Preferred Urgent Care may release information to doctors, nurses and other who provide me with health care or are prospective health care providers; to government agencies as authorized by law to insurance companies or others who are responsible for paying my medical bills; or to a court of law that issues a subpoena or court order. I understand this information may be released either orally or in document form.

NO GUARANTEE: I acknowledge that the practice of medicine is not an exact science and that the providers at Preferred Urgent Care have made no guarantees or warranties to me as to the result of treatments or examination.

I hereby authorize Preferred Urgent Care to release any information acquired in my examination or treatment necessary to process my insurance claims. I release you from all legal responsibility that may arise from the act I have authorized. I request payment under the medical Insurance program be made directly to the provider of service on any unpaid bill for services provided. I permit a copy of this authorization to be used in place of the original.

I have read all the provisions listed above and agree to the terms above. Changes to any provision of this agreement will not affect the validity of any other provision in this agreement.

____

Signature of Patient or Authorized Representative *Print Patient's Name* *Date*