questcare MEDICAL CLINIC

Questcare Medical Clinic

NEW PATIENT / UPDATED CONTACT INFORMATION

Patient's Name:_____ Date: _____

Address:_____ Time:_____

_____ Patient's Gender: M☐ F☐
City State Zip

Date of Birth:_____ Patient's Age: _____ New Patient☐ or Updating Info☐

Primary Phone #:_____Work/Home/Cell Secondary Phone #:_____ Work/Home/Cell

Email:_____ SSN:_____-____-_____
Email address is used for 48 hour patient follow-up by our nurses

Emergency Contact Name: _____ Phone #: _____Relation:_____

May we discuss medical information with this contact? Yes☐ No☐

Preferred Methods of Contact? Email☐ Text☐ Voice Mail/Telephone☐ Postal Mail☐

Preferred Pharmacy & Crossroads:_____

Guardian's Name, If Patient Under 18:_____ Relationship to Patient:_____

Guarantor (If different than subscriber): _____ Relationship to Patient: _____

Primary Insurance Company:_____ Subscriber ID _____ Group # _____
Subscriber Name:_____ Relationship to Patient:_____
Subscriber Date of Birth:_____ Subscriber SSN:_____

Secondary Insurance Company:_____ Subscriber ID _____ Group # _____
Subscriber Name:_____ Relationship to Patient:_____
Subscriber Date of Birth:_____ Subscriber SSN:_____

Subscriber Address (billing address, if different from above):_____

Please list any food or medication allergies: _____

Are you currently pregnant? No ◯ Yes ◯ Date of last menstrual period: _____

Continued on back.

Name:_____DOB:_____DATE:_____

My protected health information may be released by all methods checked:

work phone ☐ work voice mail ☐ home phone ☐ home voice mail ☐ cell ☐ cell voice mail ☐ mail ☐

_____**Consent for Treatment and Payment Agreement:** I consent to Questcare Medical Clinic's administration and performance of general treatment, use of prescribed medications, performance of diagnostic procedures, tests and cultures, and performance of other laboratory tests that my physician or his designee determines medically necessary or advisable based on the judgment of my physician or their assigned designees. I give this consent in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in force until revoked in writing; and a revocation of this consent will not affect the validity of my consent as to acts performed prior to the revocation. I understand that my consent on this form extends to practice locations affiliated with Questcare Medical Clinic. A photocopy of this consent shall be as valid as the original. I understand that while my consent is voluntary, if I refuse to sign this consent, Questcare Medical Clinic may refuse to treat me.

_____**Minor/Disabled Patient:** If I am signing this consent on behalf of a patient who is under age 18 or impaired in such a way as to make him or her unable to consent to or refuse treatment, I represent to Questcare Medical Clinic that I have the legal authority to consent to treatment on the patient's behalf and that I do in fact consent to treatment as described in the preceding paragraph. In such a case, references in this form to "I," "me," or "my" are intended as references to the patient where appropriate in the context.

_____**Exposure Testing:** I understand that in the case of an accidental exposure to blood or other bodily fluids, state law allows Questcare Medical Clinic to perform an HIV test without obtaining the patient's consent on a patient who may have exposed a healthcare worker to HIV.

_____**Patient Responsibility for Follow-Up:** I understand that it is my responsibility to follow any discharge and/or follow-up instructions Questcare Medical Clinic may provide to me, including without limitation any recommended home-care and any follow-up examination and/or treatment by other healthcare providers. I accept full responsibility for the consequences of any failure by me to obtain recommended follow-up care and/or to comply with any other discharge instructions related to this Questcare Medical Clinic visit.

_____**Responsibility for Payment:** In consideration of the services Questcare Medical Clinic will provide to me, I promise to pay Questcare Medical Clinic's charges for such services. I understand Questcare Medical Clinic may file its bill with my insurance company, but I understand that it is my responsibility to obtain any referral forms from my primary care physician that my insurance company may require as a condition to its payment for my healthcare service. I understand that the cost of healthcare services provided to me is my personal responsibility, even if I have insurance coverage for that cost, and that I am directly liable to Questcare Medical Clinic for any portion of such cost that my insurance company or other third-party payer does not pay, for any reason. If I am signing this form on behalf of a person whom I have allowed to be a dependent on my insurance coverage, I acknowledge that I am personally liable for any copayment, deductible obligation, or other portion of Questcare Medical Clinic's charge for services to that person that my insurance company or other third-party payer does not pay. If the patient is my minor child, I acknowledge that I am legally responsible to Questcare Medical Clinic for its charges for services to the patient without regard to the allocation of liability for such charges as between other persons and me in a decree of divorce or other court order or decree. I understand that if my account with Questcare Medical Clinic is unpaid for more than a reasonable amount of time Questcare Medical Clinic will place my account with a collection agency and, if necessary, cause my unpaid account to appear on my credit report. I agree to endorse and forward to Questcare Medical Clinic all insurance or third-party payments that I receive for services Questcare Medical Clinic has rendered to me, immediately upon my receipt of such payments.

_____**Medical Records:** I understand that Questcare Medical Clinic maintains medical records in the office which will be used on an ongoing basis for planning care and treatment. Information within the medical record may be released by Questcare Medical Clinic to my other physicians/healthcare providers and insurance company as necessary for billing and medical reasons. I authorize Questcare Medical Clinic to access my prescription history from external sources. MEDICARE PATIENTS: I authorize Questcare Medical Clinic to release my medical information to the Social Security Administration or its intermediaries for my Medicare Claims. I assign the benefits payable for services to Questcare Medical Clinic.

_____**Email:** If I have provided my email address on this form, I understand that Questcare Medical Clinic will keep that address confidential and will not rent or sell it. I understand that Questcare Medical Clinic has requested my email address in case Questcare Medical Clinic needs to contact me. I consent to Questcare Medical Clinic's sending me, as a courtesy, 48-hour patient follow-up communications, satisfaction surveys, or urgent notices. I consent to Questcare Medical Clinic sending unsecured emails regarding my Questcare Medical Clinic visit to the email address I have provided on this form.

I acknowledge that I have received or been given the opportunity to receive a copy of the HIPAA Privacy Policies and understand that if I have any questions or complaints, I should contact the Questcare Medical Clinic's Privacy Officer: Melissa Brewster, QRx Clinic Services at 214.705.1155 ***_____ **(Patient/Guardian Initials)

_____ _____

Patient / Responsible Party Date m/d/y