URGENT CARE extra
when you can't wait to feel better

PATIENT MEDICAL HISTORY

☐ Male

Patient Name: _____ Date of Birth: _____ Gender: ☐ Female

Phone Number:_____

Reason for visit:

_____

_____

Medicine Allergies: NONE

_____

_____

Current Medications: NONE

_____

_____

Past Medical History: NONE

_____

_____

☐ Check box if you have a FAMILY HISTORY of: Cancer, Diabetes, Hypertension or Heart Disease

☐ Check box if you have a SOCIAL HISTORY of: Tobacco, Alcohol, or Recreational Drugs

☐ Check box if you have recently TRAVELED or LIVED OUTSIDE OF THE US

Prior Surgeries:

_____

_____

Patient/Guardian Signature: _____ Date: _____

Physician Signature: _____

URGENT CARE
when you can't wait extra to feel better

PATIENT INFORMATION

Patient Name: _____
FIRST MIDDLE LAST

Date of Birth:_____ Gender: ☐ Female ☐ Male

Mailing Address:_____Apt #:_____
City:_____ State:_____ Zip: _____
Home Phone # :_____ Cell #:_____
Email Address:_____

MINORS ONLY

Mothers Name(First, Middle, Last):_____ Date of Birth:_____
Fathers Name(First, Middle, Last):_____ Date of Birth:_____

INSURACE SUBSCRIBER INFORMATION: (IF you are not the subscriber)

Subscriber's name_____

Subscriber's Date of Birth_____

Subscriber's SSN_____

All insurance coverage and charges are different depending on your agreement with your carrier. Copayments, deductibles, specific coverage for services is determined by your Insurance company depending on the plan you have.

If you feel that your insurance deductible is too high, you may be seen today at our **low cash rate**. (ask our front office associate about this)

INSURANCE INFORMATION

◯ If you have a **copy of your insurance card**, please provide it to the FRONT OFFICE. If you have 2 insurances, please provide both cards.

◯ Please provide a copy of your **driver's license or other ID** to the FRONT OFFICE **Not required for CASH visits**

◯ **If you do not have your insurance card**, please provide you SSN_____ so we can verify your insurance coverage

MEDICAL TREATMENT AND FINANCIAL AGREEMENT

We at East Valley Urgent Care would like to take the time to personally thank you for choosing us as your Urgent Care and Rehabilitative provider and we hope we can help you in your journey towards improved health. Our foremost goal is patient satisfaction and providing quality, affordable medical care. Feel free to ask any of our staff questions regarding your treatment or progress and let us know if there is a better way in which we can assist you. We ask that you read, sign and return this form to us prior to your treatment.

CONSENT FOR MEDICAL TREATMENT

Patient, or patient's legal representative, agrees to the following terms of treatment:

I, the patient or authorized representative, consent to any examination, evaluation and treatment regarding any illness, injury and/or other health concern affecting me at any time I am present at East Valley Urgent Care for treatment. These services may include, but are not limited to laboratory procedures, x-ray examinations, and medical and/or surgical treatment procedures.

FINANCIAL POLICY

- All patients must provide to East Valley Urgent Care accurate and complete personal and insurance information prior to being seen by the doctor.
- Payment is required at the time of service and may be in the form of cash or credit card. If paying by credit card, please be aware East Valley Urgent Care accepts Visa, MasterCard, Discover and American Express.
- We will be glad to file on your behalf a claim with your insurance provider. It is your responsibility to comply with any pre-determination or notification requirements as required by your insurance provider. Many of the services provided by East Valley Urgent care may be covered benefits under your insurance plan, but how those benefits are paid or whether certain services are considered non-covered is determined by your insurance provider. It is your responsibility to understand the limitations and exclusions of your plan.
- In all cases we require the guarantor (the person who is financially responsible) to be personally liable for all balances
- East Valley Urgent Care believes the fees associated with its services are reasonable and customary fees for our region and specialty. If your insurance provider uses a different fee schedule, you may be responsible for any remaining balance(s).
- East Valley Urgent Care may charge reasonable fees for services related to your account including, but not limited to returned check fees, interest on unpaid accounts and copies of medical records.
- Should East Valley Urgent Care find it necessary to forward an account balance to a collection agency, the guarantor is financially responsible for all charges incurred from said agency.
- Your personal information will be updated at least once yearly to verify the information currently on file is correct.
- East Valley Urgent Care may collect a deposit on the charges you incur today applicable to your balance, (e.g. copay, deductible and/or self pay) and bill you for any remaining balance(s). All bills are due upon receipt.
- Federal laws require that we submit every claim to an insurance company accurately and report the exact services performed and the exact reason for performing them. We will not change any information just so the insurance provider can/will pay the claim.

I understand this medical treatment and financial agreement will be valid for all services provided at East Valley Urgent Care from the date signed forward. I have read the above policies and agree to follow the terms as outlined within. I am the patient, the parent of a minor child, or the legally authorized representative of the patient and am duly authorized to act on behalf of the patient and to sign this agreement.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Relationship to Patient Witness

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

During the course of serving your interests it may be necessary to share your information with other health care providers or business associates. The following are examples of instances where information may be shared:

- Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluation your health, diagnosing medical conditions and providing treatment. For example, results of laboratory test and procedures will be available in your medical record for all health professionals who may provide treatment or who may be consulted by staff members.
- For payment purposes, your health information may be used to seek payment from your health plan, from other sources of coverage such as an auto insurer or from credit card companies that you may use to pay for services.
- Our staff may use your health information to send you follow-up care, referral or appointment reminders, or to inform you of changes made to our facilities.
- Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations and to comply with government mandated reporting
- Your healthcare information may be used as necessary to support the day-to-day activities and management of East Valley Urgent Care.
- Your health information may be disclosed to public health agencies as required by law.
- If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided for by law

As a patient, you have certain rights under the federal privacy standards that include:

- The right to request restrictions on certain uses and disclosures of protected health information. As a provider, we are not required to agree to these requests
- The right to receive confidential communications of your protected health information
- The right to inspect and copy your protected health information
- The right to amend your protected health information
- The right to receive an accounting of disclosures of your protected health information
- The right to receive a printed copy of this notice

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by change in federal and state laws and regulations. Upon request we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

If you have any questions, comments or complaints regarding our privacy practices or feel your privacy rights have been violated, contact our Billing Office by phone at **(480) 988-9108** or mail at **3336 E Chandler Heights Rd, Ste 121, Gilbert AZ 85298**. You may also send a written complaint directly to the U.S. Department of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

I have read and understand the above Notice of Privacy Practices.

_____ _____

Signature of Patient or Legal Guardian Date

IF YOU ARE USING AN INSURANCE BENEFIT PLAN, THE FOLLOWING IS WHAT TO EXPECT PRIOR TO AND FOLLOWING YOUR VISIT TODAY:

1. If you are paying with insurance today – The amount of your co-pay and your deductible were determined when you signed up for your insurance plan. Please make sure to contact your insurance company if you have any questions regarding these two items.
2. In addition to your co-pay (as determined by you and your insurance company), you must meet the deductible amount that you chose when signing up for your specific plan. Please make sure to contact your insurance company to verify if your deductible amount has been met for the year, or if any deductible amount remains on your plan.
3. You will receive an "Explanation of Benefits" letter (EOB) from your insurance company following your visit. That letter will explain in detail what insurance benefit(s) they have provided to you, and they may be as follows:
   A. The discounted charges for being a part of their insurance group
   B. How much they paid on your behalf
   C. How much you still owe for the visit
   D. If you have met your deductible for the year, there would be no additional payment (unless a co-pay is required at the time of your visit)

ALL INSURANCES ARE DIFFERENT, AND SOME INSURANCE COMPANIES WILL COVER 100% OF YOUR VISIT(S), WHILE OTHERS MAY NOT COVER YOUR VISIT(S) AT ALL. EVERY INSURANCE COMPANY WILL HAVE MULTIPLE PLANS TO CHOOSE FROM. THOSE PLANS WILL RANGE FROM HIGH DEDUCTIBLES TO NO DEDUCTIBLES, AND/OR ALONG WITH HIGH CO-PAYS TO NO CO-PAYS.

MOST INSURANCE COMPANIES LIST THE CO-PAY AND/OR DEDUCTIBLE AMOUNT ON YOUR INSURANCE CARD HOWEVER; THEY DO NOT LIST HOW MUCH OF YOUR DEDUCTIBLE HAS BEEN MET FOR THE YEAR. YOUR INSURANCE COMPANY WILL HAVE ALL OF THIS INFORMATION, AS YOUR VISIT FEES HAVE BEEN PREDETERMINED BY THE TYPE OF INSURANCE PLAN YOU HAVE SELECTED.

FOR ANY QUESTIONS REGARDING THIS INFORMATION, PLEASE CONTACT OUR BILLING SPECIALISTS AT:

PHONE: 480.988.9108
FAX: 480.988.0061
ADDRESS: 3336 E CHANDLER HEIGHTS RD STE 121, GILBERT, AZ 85298

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____

DATE: _____

WITNESS (EMPLOYEE): _____

DATE: _____