Classic Urgent Care

PATIENT CHECK IN WORKSHEET

First Name:_____ **Middle:**_____ **Last:** _____

Date of Birth:_____/_____/_____ **SSN:**_____-_____-_____ **Sex**: Male ☐ Female ☐

Home #: (_____) _____-_____ **Cell #:** (_____) _____-_____ **Email:** _____

Address:_____ **Apt/Suite:**_____ **City:**_____ **State:**_____ **Zip Code:** _____

Emergency Contact:_____ **Phone #:** (_____) _____-_____ **Relationship:** _____

Reason for your visit: _____

(Examples include: Cough, Ear Infection, Fever, Flu, Rash, Sinus Infection, Injury, Urinary, etc.)

Are you here due to injuries from a car accident or work injury? ☐Yes ☐No
Do you need a doctor's note for school or work? ☐Yes ☐No
Do you need a paper copy of your discharge summary? ☐Yes ☐No

List All Medical Insurance(s): _____

Preferred Pharmacy:_____ **Address/ Cross Streets:** _____

*If you **DO NOT** wish to receive a follow up call, check here*

ADDITIONAL INFORMATION

How did you hear about us? ◯Friend/Family ◯Drive-by ◯Yelp ◯Facebook ◯Google ◯Military Dir. ◯Ins. Dir. ◯Dr. Referral Phonebook

Race: American Indian/Alaska Native ◯ Asian ◯ Black/African American ◯ Native Hawaiian/Pacific Islander ◯ White ◯ *Patient Declines* ◯

Ethnicity: ◯Hispanic or Latino ◯ Not Hispanic or Latino ◯ *Patient Declines*

Preferred Language: ◯English ◯Spanish ◯Vietnamese ◯Other_____ ◯*Patient Declines*

PARENT/ LEGAL GUARDIAN IS NOT PRESENT CONSENT

The patient's legal guardian *(full name)*_____ has authorized Classic Urgent Care to treat minor with

*(name/relation to minor)*_____. Legal guardian phone #: (_____) _____-_____

GUARANTOR*(PERSON FINANCIALLY RESPONSIBLE FOR MINOR)*

Name:_____ DOB:_____ Relation: _____

Address:_____ Apt/Suite:_____ City:_____ State:_____ Zip Code: _____

AUTHORIZATION & AGREEMENT

HIPAA Patient Consent

By signing below, I have read and fully understand the Patient Consent for Use and Disclosure of Protected Health Information, rev. 7/ 2016. I consent and agree to all of its terms and conditions. I understand copies of Classic Urgent Care's full Notice of Privacy Practices are available on request.

Patient Responsibility and Financial Policy Clause

By signing below, I have read and fully understand Classic Urgent Care's Patient Responsibility and Financial Policy. I accept and agree to all of its terms and conditions. Specifically, I understand that I am responsible for any medical treatment and medical equipment not covered by my insurance plan or applied towards my copay, coinsurance, and/or deductible. These services include, but are not limited to: Injections (administration fee & medicine), IV treatments and fluids (initial IV treatment, hydration, medicine, etc.), and durable medical goods (crutches, walking boots, splints, slings, ace wraps, etc.) I understand that balances may be assessed interest and collection fees. I understand that any overpayments may remain as a credit balance on my account, to be applied to future charges, unless I request a refund.

Consent for Treatment

By signing below, I understand that I have a choice to be seen at Classic Urgent Care versus the hospital Emergency Department, my primary care, or a specialist. I authorize Classic Urgent Care to provide medical treatment and services to me. I understand I am authorizing Classic Urgent Care to treat me while I seek care from Classic Urgent Care or until I withdraw my authorization in writing.

Patient Signature_____ **Date**_____/_____/_____

I declare the above information is true. I authorize my insurance benefits to be paid to Classic Urgent Care. I understand that I am financially responsible for any charges that may not be covered by my insurance plan. I authorize my medical information to be released to my insurance company/ any of its affiliates for medical purposes.