PRIMECARE
URGENTCARE

☐ NEW PATIENT ☐ ESTABLISHED PATIENT

## PATIENT INFORMATION

NAME: _____ (LAST) _____ (FIRST) _____ (MIDDLE) AGE: _____ F or M

DOB: _____ SSN: ___ - ___ - ___ Single Married Divorced Widowed Other

ADDRESS: _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

PHONE: _____ (HOME) _____ (WORK) _____ (CELL/PAGER)

EMPLOYER: _____ E-MAIL: _____

## EMERGENCY CONTACT (MUST BE RESPONSIBLE PARTY IF PATIENT IS A MINOR)

NAME: _____ (LAST) _____ (FIRST) _____ (MIDDLE) DOB: _____

ADDRESS: _____ (STREET (IF DIFFERENT FROM ABOVE)) _____ (CITY) _____ (STATE) _____ (ZIP)

PHONE: _____ (HOME) _____ (WORK) _____ (CELL/PAGER)

EMPLOYER: _____ RELATION TO PATIENT: _____

## INSURANCE INFORMATION

PRIMARY INSURANCE: _____ ID #: _____ GROUP #: _____

INSURED NAME: _____ DOB: _____ RELATION TO PATIENT: _____

SECONDARY INSURANCE: _____ ID #: _____ GROUP #: _____

INSURED NAME: _____ DOB: _____ RELATION TO PATIENT: _____

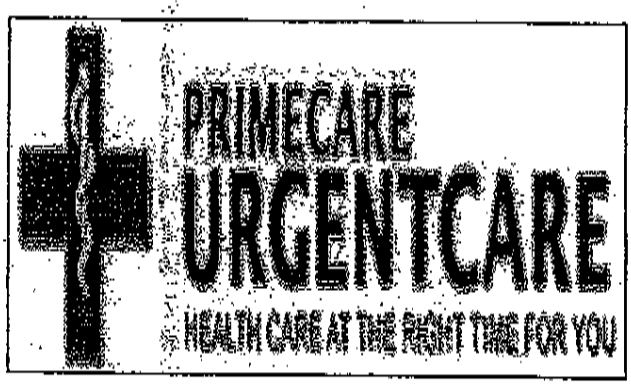
## REFERRAL INFORMATION

HOW DID YOU LEARN ABOUT PRIMECARE? ☐ DRIVE-BY ☐ BILLBOARD ☐ INTERNET

☐ PHONE BOOK ☐ UP IN CUMMING ☐ FORSYTH LIVING ☐ REFERRAL _____ (SOURCE)

_____ Signature of Person Filling out Form

_____ Date




# NOTICE OF PRIVACY PRACTICES
# PATIENT ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____

I have received and understand this practice's Notice of Privacy Practices written in the plain language. This notice provides in detail the uses and disclosures of my protected health information. ("PHI") that may be made by this practice, my individual rights, how I may exercise these rights, and this practice's legal duties with respect to my protected health information.

I understand that this practice reserves the right to change the terms of its' Notice of Privacy Practices, and to make changes regarding all protected health information residing at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practice upon request.

Patient Signature: _____

(Relation to patient if signed by representative of patient (parent, guardian, medical power of attorney):

_____

Date: _____

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## PAYMENT AND INSURANCE POLICY

As a patient or guardian, it is in your best interest to know and understand your insurance benefits and coverage. PrimeCare Medical Center and Urgent Care, hereby referred to as PrimeCare, will collect all co-payment, co-insurance, and deductible amounts prior to your visit. PrimeCare is not contracted with every insurance company and cannot be responsible for knowing the terms and conditions of your specific plan. As a courtesy we will gladly submit a claim to you insurance carrier for possible payment but ultimate financial responsibility belongs to you as the patient or guarantor. If you are unsure of your medical benefits you should contact your insurance company to verify coverage and participation guidelines. If PrimeCare is a participating provider under your insurance plan, we will bill and collect from your insurance carrier for covered services. You, the patient or guardian, have the responsibility of obtaining any prior authorization or approval that may be required by your insurance carrier. You will also be responsible for any deductible and/or co-insurance amounts as well as any non-covered charges. If PrimeCare does not participate with your insurance plan we may still accept your insurance and submit a claim on your behalf. Many insurance companies and managed care programs offer out-of-network benefits and will issue payment for a certain percentage of the overall claim amount. The remaining percentage will become "patient liability" and you will be responsible for the balance. If your insurance policy does not provide out-of-network benefits, the entire balance of the claim will become your responsibility. PrimeCare cannot guarantee payment of your claims or accept responsibility for negotiating claims on your behalf. It is your responsibility, as a patient or guarantor, to be familiar with your insurance benefits. In the event that your insurance company suspends a claim due to additional information required from you, you will be responsible for the total amount until you provide the necessary information to your insurance company and the claim has been processed.

## PAYMENT

Payments may be made by cash, MasterCard, Visa,

PrimeCare requires patients without insurance or without valid proof of insurance to pay for the entire visit prior to service. All other payments will be due upon receipt of a statement. All balances not paid in a timely manner will be turned over to a collection agency and you will be held responsible for any collection agency costs, court cost, and/or attorney's fees incurred in the collection of an outstanding balance for service rendered to you or your dependant.

## WORK RELATED INJURY OR ILLNESS

If you are being treated for a work-related injury or illness, PrimeCare will gladly file your worker's compensation claim once we have received all necessary information including carrier name, claim address and telephone number, claim reference number, date of injury and authorization of treatment by your employer.

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## CONSENT FOR TREATMENT AND ASSIGNMENT OF BENEFITS

I hereby consent, for myself or dependent, to diagnostic and/or therapeutic medical treatment, procedures and medical imaging as deemed necessary by the provider. I acknowledge that there is no guarantee as to the result of any procedure performed or any medical treatment provided. In addition I authorize all payments for services rendered to myself or dependants, which are payable to me under the terms of my insurance policy, to be paid directly to PrimeCare for services provided. I assume full financial responsibility for any charges not paid by my insurance company.

I certify that the information I have provided is true and correct. I am aware that knowingly providing false information regarding my identity, insurance coverage etc. constitutes fraud.

Signature of Patient/ Guardian _____ Date _____

Name of Patient/ Guardian (Please Print) _____

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## DISCLOSURE OF HEALTH CARE INFORMATION NOTICE

I understand that as part of my healthcare, PrimeCare Medical Center & Urgent Care (hereby referred to as PrimeCare) originates and maintains paper and/or electronic records describing my demographic information as well as records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information may serve as:

- ✓ A basis for planning my care and treatment.
- ✓ A means of communication among the many health professionals who may contribute to my care.
- ✓ Information for applying my diagnosis and surgical information.
- ✓ A means by which a third-party payer can verify that services billed were actually provided.
- ✓ A tool for routine healthcare operations such reviewing the competence of healthcare professionals and assisting quality.
- ✓ A means by which to contact me regarding my treatment, follow-up, and various test results.

I understand that I have the following rights and privileges:

- ✓ The right to review the "Notice of Information Practice" prior to signing this consent.
- ✓ The right to object to the use of my healthcare information for directory purposes.
- ✓ The right to request restrictions as to how my healthcare may be used or disclosed to carry out treatment, payment or healthcare operations.
- ✓ The right to revoke any prior consent, as provided in writing, except to the extent that the organization has already taken action.

I understand that PrimeCare is not required to agree to the restrictions requested. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that PrimeCare reserves the right to change their notice of privacy practices. I will be notified of the changes in writing, upon my next visit.

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax and/or e-mail.

In the event PrimeCare refers me to a SPECIALIST, I hereby authorize PrimeCare to release my medical records to the SPECIALIST and also to authorize the SPECIALIST to release my medical records and SPECIALIST REPORTS back to PrimeCare.

I wish to implement the following limitations or allowances regarding the use or disclosure of my healthcare information:

_____

_____

_____

I fully understand and ☐ ACCEPT ☐ DECLINE the terms of this consent. (Please check one)

_____ _____

Patient or Guardian Signature Date

_____ _____

Witness Date

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# Patient Health History

Patient's Name _____ Date of Birth _____ MR# _____

Please answer 'Yes' or 'No' to the following Health History questions, and elaborate if needed.
Your answers are for *PrimeCare*'s records only and considered confidential.

**Medical History**

Allergies ..... Yes [] No []
Anemia ..... Yes [] No []
Anxiety..... Yes [] No []
Arthritis ..... Yes [] No []
Asthma ..... Yes [] No []
Bone Fractures ..... Yes [] No []
Cancer ..... Yes [] No []
Chemotherapy..... Yes [] No []
Chest Pain ..... Yes [] No []
Chronic Pulmonary Disease..... Yes [] No []
Depression..... Yes [] No []
Diabetes..... Yes [] No []
Dizziness/Fainting..... Yes [] No []
Epilepsy or Seizures..... Yes [] No []
Excema or Skin Disorder..... Yes [] No []
Frequent Headaches..... Yes [] No []
Gall Bladder Disease..... Yes [] No []
Glaucoma or Cataracts ..... Yes [] No []
Hearing Disorder..... Yes [] No []
Heart Disease..... Yes [] No []
Heart Murmur..... Yes [] No []
Hemophilia (Bleeding Disorder) ..... Yes [] No []
Hepatitis..... Yes [] No []

High Blood Pressure..... Yes [] No []
High Cholesterol ..... Yes [] No []
Insertion of Pacemaker ..... Yes [] No []
Kidney or Bladder Disease ..... Yes [] No []
Liver Disease ..... Yes [] No []
Memory Loss ..... Yes [] No []
Menstrual Dysfunction ..... Yes [] No []
Mental Illness ..... Yes [] No []
Rheumatic Fever ..... Yes [] No []
Scarlet Fever ..... Yes [] No []
Sexual Dysfunction..... Yes [] No []
Sexually Transmitted Diseases..... Yes [] No []
Stroke..... Yes [] No []
Thyroid Disease..... Yes [] No []
Tuberculosis..... Yes [] No []
Ulcers (stomach) ..... Yes [] No []
Women: Are You Pregnant? ..... Yes [] No []
Date of LMP? _____
Are you taking birth control?..... Yes [] No []

# of Pregnancies _____ # of Live Births _____
# of Miscarriages _____
Have you gone through Menopause? Yes [] No []

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Have you ever had **Surgery** of any type? ..... Yes [] No []

_____

_____

**Medications**

Are you taking any of the following?

Anticoagulants (blood thinners) ..... Yes [] No []
Medicine for High blood pressure .... Yes [] No []
Tranquilizers or Sedatives ..... Yes [] No []

Diabetic or Blood Sugar ..... Yes [] No []
Insulin ..... Yes [] No []
Oral Drugs ..... Yes [] No []

(Please List)
Other Medications: _____

_____

_____

# PRIMECARE
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Are you Allergic to or have you reacted adversely to:
Local Anesthetics ..... Yes [] No []
Penicillin ..... Yes [] No []
Other Antibiotics ..... Yes [] No []
Latex ..... Yes [] No []
Foods ..... Yes [] No []
Other Allergies: _____

**Social History**
Do you Smoke .....Yes [] No [] # of Years _____ Packs per day _____
Quit when? _____
Do you dip Snuff? ..... Yes [] No [] How much? _____ How often? _____
Quit when? _____
Do you drink Alcohol? .....Yes [] No [] How much? _____ How often? _____
Do you use street Drugs? ..... Yes [] No [] Type _____
Have you ever tested positive for HIV/AIDS? ..... Yes [] No []
Have you ever required a blood Transfusion? .....Yes [] No [] If so, explain the circumstances: _____

**Family History:** List any family (blood relative) that had the following:
Heart Disease ..... Yes [] No []
Depression ..... Yes [] No []
Diabetes ..... Yes [] No []
Glaucoma ..... Yes [] No []
High Blood Pressure ..... Yes [] No []
High Cholesterol ..... Yes [] No []
Cancer ..... Yes [] No []
Tuberculosis ..... Yes [] No []
Stroke ..... Yes [] No []
Alcoholism ..... Yes [] No []
Mental Illness ..... Yes [] No []

**Review of Systems:** List any of your individual Symptoms in the following Body Areas:
Constitutional: Fever, Sweats, Weight Loss or Gain____
ENT: Ear Pain, Nose Drainage, Sore Throat_____
Respiratory: Cough, Congestion, Wheezing _____
GU: Urinary Pain, Rash, Discharge, Abnl Bleeding ___
Skin: Rash, Blisters, Ulcers, Burn, Abrasions, Cuts ____
Psychiatric: Anxious, Depressed, Stressed _____
Heme/Lymphatic: Anemia, Cancer, Leukemia, DVT___
Eyes: Pain, Red, Discharge, Jaundice, Visual Loss _____
Cardiovascular: Chest Pain, Angina, Palpitations, _____
GI: Abd Pain, Nausea, Vomiting, Diarrhea, Blood _____
MusculoSkeletal: Neck, Back, Joint Pains, Swelling ___
Neurologic: Weak, Numb, Dizzy, Fainting, Falls _____
Endocrine: Low Thyroid, Diabetes, Adrenal _____
Allergies/Immune: Hayfever, Chemotherapy _____
Other Symptoms: _____

Do you have any disease, condition or problem Not listed above that you think I should know about? .... Yes [] No []
_____

The information that I have provided above is true and correct to the best of my knowledge.

_____
Patient, Parent or Guardian's Signature Date

_____
Your Name (Please Print) MR#