

NEW PATIENT INTAKE FORM

**** Please be aware that the name and sex at birth you have listed on this form and on your insurance card must match. This information will be used on documents pertaining to insurance, billing, and correspondence. ****

Have you visited a doctor's office or hospital in the past 24 hours? **YES / NO** *(Circle One)*

Reason for Visit: _____ **SSN:** _____ - _____ - _____

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

Preferred Name: _____ **Middle Name:** _____

Date of Birth: _____ / _____ / _____ **Sex at Birth:** Male Female Unknown *(Circle One)*

Mailing Address: _____ **County:** _____

City: _____ **State:** _____ **Zip:** _____

Email: _____

Cell Phone: (_____) - _____ - _____ Okay to leave voicemail? **YES / NO**

Home Phone: (_____) - _____ - _____ Okay to leave voicemail? **YES / NO**

Primary Care Provider (PCP) _____

(PLEASE NOTIFY THE FRONT DESK STAFF IF YOU HAVE A PCP)

Preferred Pharmacy: _____ - _____ , _____
(Name) (City) (State)

Emergency Contact: _____ **Relationship:** _____

Emergency Contact Phone Number: (_____) - _____ - _____

Ethnicity: Decline Response Not Hispanic or Latino Hispanic or Latino

Race: American Indian or Alaskan Native Black or African American Native Hawaiian or Pacific Islander
 Asian White Decline Response Other

Preferred Language: _____

Primary Insurance Name: _____ **Member ID:** _____

Subscriber/Policy Holder: _____

Subscriber DOB: _____ / _____ / _____ **Subscriber Relationship:** _____

Secondary Insurance Name: _____ **Member ID:** _____

Subscriber/Policy Holder: _____

Subscriber DOB: _____ / _____ / _____ **Subscriber Relationship:** _____

I voluntarily present to QuickVisit Urgent Care and consent to treatment of the physician on duty and whomever they may designate as their assistant, associate, treating physician and patient care staff to provide my care. Such care may include, but is not limited to, diagnostic procedures, radiological evaluations and procedures, and the administration of medications considered advisable in my diagnosis, treatment, and course of care. I acknowledge that no guarantee can be made or has been made as to the results of treatments/examinations, and I understand that all medical treatments contain inherent risks.

Patient or Legal Guardian Name: *(Print)* _____

Relationship to Patient: _____

Patient or Legal Guardian Signature: _____

Date: _____ / _____ / _____

CONSENT FORM

Communication Consent Language:

I expressly consent and agree that QuickVisit Urgent Care, and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith may contact me by telephone at any number associated with the Accounts, which could result in charges to me. I expressly consent and agree that QuickVisit and its affiliates may also contact me by sending text messages, emails, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts at any telephone number associated with my account regardless of whether I incur charges as a result. By signing below, I also consent to receiving patient communication and marketing information via email and/or text message. I understand that I am able to opt-out if I no longer want to receive communications.

Patient Financial Obligation

I understand that all applicable co-payments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to QuickVisit for services rendered. I authorize representatives of QuickVisit to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim. I understand that verification of benefits does not guarantee payment by my insurance company. I understand if I do not have insurance, I will receive a self-pay discount due at the time of service. I understand if the self-pay amount is not paid in full at time of service, I may receive a bill for fee scheduled amount for services rendered. I understand I may receive bills from third parties for any labwork and/or medical equipment (i.e., crutches, slings, etc.) outsourced by QuickVisit.

Outstanding Balance Agreement:

By signing below, I authorize QuickVisit Urgent Care to keep my signature and my credit card information securely on-file in my account. I authorize QuickVisit Urgent Care to charge my credit card for any outstanding balances when due for balances (not to exceed \$75.00 in a 30-day span) for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me. This authorization will remain in effect until I cancel this authorization. To cancel, I must give 30-day notification to QuickVisit Urgent Care in writing and the account must be in good standing. Your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notifies us of the balance due, if any. Balances owed will be applied to the card on file. These transferred amounts are outlined in the Explanation of Benefits (EOB) that is mailed to you by your insurance company. Your ability to dispute a charge or question your insurance company's determination of payment will remain unchanged. If you have any questions about our policy, please read the FAQs form.

External Pharmacy Records Consent:

I understand that the prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be accessed by QuickVisit Urgent Care. This may include prescriptions dating back several years.

Notice of Privacy Practices:

I acknowledge that I was provided with a copy of the QuickVisit Notice of Privacy Practices (NOPP).

Information Disclosure and Consent:

QuickVisit will provide you with the health plans that your provider(s) accepts. If you decide to be treated by a provider who does not accept your health plan, you will be asked to sign a consent form agreeing that you accept treatment from that provider.

I have read and agree to all the above (Communication Consent Language, Patient Financial Obligation, Outstanding Balance Agreement, External Pharmacy Records Consent, Notice of Privacy Practices, and Information Disclosure and Consent).

Patient or Legal Guardian Name: *(Print)* _____

Patient or Legal Guardian Signature: _____

Date: _____ / _____ / _____



SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices.

This Summary describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We understand that your medical information is personal to you, and we are committed to protecting this information. As our patient, we create medical records about your health care for you and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information (PHI) is kept private. How will we use or disclose your information? Here are some examples. For more detail, please ask our Front Office.

- For medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient recall reminders
- Health Care Operations
- Communication and Education
- For research
- Monitoring Public Health Risk & Safety
- For organ and tissue donation
- For Worker's Compensation programs
- In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our Office Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to access/copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

For more information about these rights, please see the detailed Notice of Privacy Practices, available upon request at the Reception Desk.