*HOW DID YOU HEAR ABOUT US?

_____SIGN
_____INSURANCE CO
_____FRIEND/FAMILY
_____ADVERTISING
_____PHONEBOOK
_____INTERNET
_____OTHER

NEW PATIENT REGISTRATION FORM

*IF YOU ARE EXPERIENCING ANY OF THE FOLLOWING, PLEASE STOP AND NOTIFY ATTENDANT IMMEDIATELY:

_____SEVERE CHEST PAINS
_____UNCONTROLLED BLEEDING
_____SEVERE SHORTNESS OF BREATH
_____SEVERE ALLERGIC REACTION
_____ANY OTHER EMERGENCIES

TYPE OF VISIT:

CHART NO.__________________

DATE OF SERVICE_____ ______

____INSURANCE (PRESENT CARD AT CHECK-IN)

____SELF PAY (PAYMENT DUE AT TIME OF SERVICE)

____ON-THE-JOB INJURY

____AUTO ACCIDENT

PATIENT INFORMATION:

PATIENT NAME: LAST: ______________________________FIRST:____________________________MI:____

DATE OF BIRTH: _ _-_ _-_ _ _ _ SOCIAL SECURITY NUMBER: _ _ _-_ _-_ _ _ _

STREET ADDRESS: ____APT:________

CITY: ____ST: _____ ZIP: ___________________

HOME PHONE: _ _ _-_ _ _-_ _ _ _ CELL: _ _ _-_ _ _-_ _ _ _ WORK: _ _ _-_ _ _-_ _ _ _

SEX: MALE____ FEMALE____ RACE: ______________ ETHNICITY: ____________

MARITAL STATUS: SINGLE_____ MARRIED_____ DIVORCED____ SEPERATED_____

PRIMARY CARE PHYSICIAN: ____

MAY WE LEAVE A MESSAGE REGARDING YOUR CARE (LAB RESULTS) ON YOUR PHONE? YES___ NO___

E-MAIL ADDRESS: ____

PARENT OR GUARANTOR'S INFORMATION:

PLEASE COMPLETE WITH NAME OF INSURED IF THE PATIENT IS NOT RESPONSIBLE FOR HIS OR HER CHARGES TODAY.

NAME: LAST: _________________________________ FIRST: _________________________________MI:___

DATE OF BIRTH: _ _-_ _-_ _ _ _ SOCIAL SECURITY NUMBER: _ _ _-_ _-_ _ _ _

STREET ADDRESS: _____________________________CITY, STATE, ZIP: _______________________________

HOME PHONE: _ _ _- _ _ _- _ _ _ _ WORK PHONE: _ _ _- _ _ _ - _ _ _ _

EMPLOYER: ____

EMPLOYMENT INFORMATION:

EMPLOYER NAME: ____

EMPLOYER ADDRESS: ____

EMPLOYER PHONE: _ _ _- _ _ _- _ _ _ _ OCCUPATION: ____

EMERGENCY CONTACT INFORMATION:

NAME: _____________________PHONE NUMBER: _______________RELATIONSHIP: ____________________

PHARMACY: ______________________________**PHARMACY'S ADDRESS**: ______________________________

PLEASE STATE THE REASON FOR TODAY'S VISIT/ DESCRIPTION OF INJURY OR SYMPTOMS:

____

____

____

IS THIS AN ON-THE-JOB OR OTHER WORK RELATED INJURY? _________YES ________NO

IF SO, PLEASE COMPLETE THE FOLLOWING:

EMPLOYER NAME: ____

SUPERVISOR: ______________________________ CONTACT NUMBER: ________________________________

DATE OF INJURY OR SYMPTOMS: ____

MEDICAL HISTORY:

LIST ALL MEDICATIONS AND DOSES (INCLUDING VITAMINS):

____

____

LIST ALL KNOW ALLERGIES AND SPECIFIC REACTIONS:

____

____

LIST ANY CHRONIC MEDICAL PROBLEMS / CONDITIONS:

____

____

LIST ALL PRIOR SURGERIES/ OPERATIONS:

____

____

ALGIERS URGENT CARE
AUC
WALK-IN CLINIC · WELLNESS CENTER

AUTHORIZATION AND RELEASE

***AUTHORIZATION FOR TREATMENT*:** I VOLUNTARILY CONSENT TO THE ADMINISTRATION AND COST OF MEDICAL AND SURGICAL PROCEDURES, X-RAY, AND MEDICATION FOR MYSELF AND MY DEPENDENTS.

ASSIGNMENT OF INSURANCE BENEITS: I AUTHORIZE PAYMENT DIRECTLY TO ALGIERS URGENT CARE CENTER FOR ALL BENEFITS OTHERWISE PAYABLE TO ME.

GUARANTEE OF PAYMENT: I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE AND AGREE TO PAY ALL OF THE CHARGES THAT ARE NOT PAID OR BILLED TO INSURANCE OR ANY OTHER THIRD PARTY PAYER. I UNDERSTAND THAT I MUST PAY IN FULL TODAY FOR ALL SERVICES RENDERED. I ALSO UNDERSTAND IF MY INSURANCE IS ACCEPTED I MUST PAY AN INSURANCE CO-PAY AND/OR DEDUCTIBLE AND CO-INSURANCE TODAY. IF YOU ARE UNABLE TO VERIFY MY INSURANCE AT TIME OF SERVICE, I WILL PAY IN FULL FOR ALL SERVICES.

RELEASE OF RECORDS*:* I AUTHORIZE ALGIERS URGENT CARE TO RELEASE (VERBAL OR IN WRITING) CONFIDENTIAL MEDICAL INFORMATION TO ANY PERSON OR ENTITY INCLUDING MY INSURANCE CARRIER, EMPLOYER IF TREATMENT IS RELATED TO EMPLOYMENT PURPOSES, OR OTHER HEALTH CARE OPERATION WHICH MAY BE LIABLETO ME OR MY PRACTITIONER(S) FOR CHARGES FOR THIS TREATMENT AND FOR QUALITY MANAGEMENT, UTILIZATION REVIEW, TRANSFER, AND FOLLOW-UP PURPOSES.

RECEIPT OF PRIVACY PRACTICES*:* I ACKNOWLEDGE THAT I HAVE RECEIVED AND READ THE NOTICE OF PRIVACY PRACTICES OF ALGIERS URGENT CARE.

I UNDERSTAND THAT A COPY OF THIS AGREEMENT MAY BE USED WITH THE SAME EFFECTIVENESS AS THE ORIGINAL.

USES AND DISCLOSURES

Here are some examples of how we might have to use or disclose your health care information:

1. Algiers Urgent Care may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
2. Our insurance and billing staff may have to disclose your treatment and billing records to another party, such as Medicare, Medicaid, other insurance carriers, outside billing company, or whoever is potentially responsible for payment.
3. Algiers Urgent Care may need to use your health information and billing records for quality control purposes to efficiently and effectively run our health care center.
4. Algiers Urgent Care may need to use your name, address, phone number, and clinical records to contact you in case of an emergency or other health related information that may be of interest to you. If you are not home to receive the message, a message will be left on your answering machine.
5. Medical information about the patient may be given to a friend or family member who is listed as responsible party or who is involved in the medical care of the patient
6. Algiers Urgent Care may place your name on any DME equipment that is used by the patient, unless instructed in writing otherwise.

PATIENT RIGHTS

1. The patient has the right to inspect and copy medical information for a fee to make decisions about the patient care.
2. The patient has the right to amend as long as the information is kept by or for the provider.
3. Covered entities must provide a statement as to how it will notify individuals on changes in privacy practices. The covered entity must retain a copy of the notice that was issued.
4. The patient has a right to an Accounting of Disclosures.
5. The patient has a right to request a restriction or limitation of the medical information disclosed about the patient. The provider is not required to agree to the request.
6. The patient has the right to a paper copy of this notice. It is only given if the patient requests it.
7. The patient has the right to revoke permission of use of the information at any time. If the patient refuses to allow their information to be disclosed for payment, treatment or health care operations, the provider can refuse to continue providing medical treatment to the patient.
8. The patient has the right to complain if they feel that their privacy rights were violated. Complaints must be submitted in writing to the Compliance Manager or the Department of Health and Human Services. The patient must be advised that he/she will not be penalized for filing.

OUR PRIVACY PLEDGE

We have and always will respect your privacy, other than the uses and disclosures we described above. We will not sell or provide any of your health information to any outside marketing organization.

______________________________	__________________________
Patient’s Name	Date
______________________________	__________________________
Patient’s Signature	AUC Representative
______________________________	__________________________
Responsible Party	Date