Martinez Urgent Care, Inc.

Patient Demographics

Name (Last, First, MI)	Gender	Date of Birth

Mailing Address	City	State	Zip

Phone Number	Alternate Number	Email Address

Social Security Number	Marital Status	Primary Language	Race

Place of Employment	Work Address	Work Phone

Emergency contact	Emergency Contact number	Relationship

Preferred Pharmacy and number

How did you hear about us? □ word of mouth □ drove by □ internet □ Insurance □ other_____

Responsible Party Information □ same as patient

Name (Last, First, MI)	Gender	Date of Birth

Mailing Address	City	State	Zip

Social Security Number	Relationship	Phone Number	Alternate Number

Primary Insurance Information	Secondary Insurance Company
□ BCBS □Aetna □Cigna □ Humana □Medicare □Other_____	□ BCBS □Aetna □Cigna □ Humana □Medicare □Other_____
Member ID:	Member ID:
Group #:	Group #:
Policy Holder:	Policy Holder:
DOB: Relationship:	DOB: Relationship:

Health Information

Are you **ALLERGIC** to any medication(s) or have any allergies?

List previous or current doctors you have seen

List current medication(s) including dosage and directions

FINANCIAL OBLIGATION FOR MARTINEZ URGENT CARE, INC

I authorize payment of medical benefits to Martinez Urgent Care, Inc. for services rendered. I understand and agree that I am financially responsible for the payment of all charges that are my responsibility for services provided regardless of insurance coverage or other third party coverage unless waived by contractual agreements between Martinez Urgent Care, Inc. and my insurer or if prohibited by state, federal laws or regulations. If the charges, that are my responsibility, are not paid within thirty (30) days of receipt of the bill, I agree to pay any additional expenses incurred due to the delinquent account including the 35% collection agency cost if the account is placed for collections. All returned checks incur a $35 service charge to be paid by cash or credit card along with the balance of the patients account within 30 days of notification by Martinez Urgent Care, Inc. or its assigned agent. Failure to comply and meet financial responsibility may also result in a patient discharge from the practice.

Signature:_____ Date:_____

HEALTH HISTORY

Please check all that apply:

- ☐ Blurred vision
- ☐ Chest pain
- ☐ Chills
- ☐ Constipation
- ☐ Depression
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Dizziness
- ☐ Double vision
- ☐ Earache
- ☐ Fainting
- ☐ Fever
- ☐ Headache
- ☐ High blood pressure
- ☐ Indigestion
- ☐ Irregular heartbeat
- ☐ Loss of hearing
- ☐ Loss of Sleep
- ☐ Low blood pressure
- ☐ Nausea
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Poor appetite
- ☐ Poor circulation
- ☐ Rapid heartbeat
- ☐ Rectal bleeding
- ☐ Sinus problems
- ☐ Smoking
- ☐ Stomach Pain
- ☐ Sweats
- ☐ Swelling of ankles
- ☐ Varicose veins
- ☐ Vomiting
- ☐ Vomiting blood

CONDITIONS

Please check any that you currently have or have had in the past:

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Cancer(specify which type) _____
- ☐ Cataracts
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Migraine headaches
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Prostate problems
- ☐ Psychiatric care
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Vaginal infections
- ☐ Venereal disease

FAMILY HISTORY

Please check if any of your blood relatives have/had any of the following and specify relationship:

- ☐ Arthritis, Gout_____
- ☐ Asthma_____
- ☐ Cancer_____
- ☐ Diabetes_____
- ☐ Heart disease_____
- ☐ High blood pressure_____
- ☐ Kidney disease_____
- ☐ Tuberculosis_____
- ☐ Other_____

HOSPITALIZATIONS/SERIOUS ILLNESS/INJURIES

Please list any of the above and include the year, name of Hospital or Doctor and outcome:

_____

CONSENT FOR TREATMENT

I, the undersigned, a patient of Martinez Urgent Care, Inc. requests and authorize my attending healthcare provider to administer as is medically necessary. I voluntarily consent to said medical care, evaluation and treatment as well as any information release necessary to obtain such. This would include such services, care, diagnostics procedures, and/or medical treatments as the physician deems reasonable and necessary. These would include but not limited to, the performance of services involving pathology, radiology and immunizations. I authorize my medical records to be disclosed/released to my insurance carrier upon their request. I acknowledge that no guarantees have been made to me as the results of treatment or examination.

X Signature: _____ ***Date:*** _____

PRIVACY NOTICE (HIPAA)

I acknowledge that it is my responsibility as a patient or parent/guardian to notify Martinez Urgent Care, Inc. in regards to any changes of the information provided verbally or contained within this patient information form to include insurance, mailing address, custody of minors and/or health information. Signature required by the patient, parent of minor child, guardian or representative/caregiver if Medicare for financial obligation, consent for treatment and privacy notice.

Please list anyone who you would like us to be able to give information to about your medical health:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

X Signature: _____ ***Date:*** _____

MEDICATION HISTORY CONSENT

Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your "medical history." A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of resources, including your pharmacy and your health insurer.

An accurate medication history is very important to helping us treat you properly and to avoid potentially dangerous drug interactions.

By signing this consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose, information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medications to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record.

This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still important for us to take the time to discuss everything you are taking and for you to point out to us any errors in your medication history.

I give permission, for Dr. Roger Brown, Martinez Urgent Care, Inc., to obtain my medication history from my pharmacy, my health plans and my other health care providers.

X Signature: _____ ***Date:*** _____

Name:	**Date of Birth:**
Incoming complaint	

PAYMENT POLICY

Thank you for choosing us as your healthcare provider. We are committed to providing you with quality and affordable healthcare. Because some of our patients have has questions regarding patient and insurance responsibility for services rendered, we have created a payment policy. Please read over it carefully, and ask us if you have any questions. At the end of reading over it fully, please sing and date. A copy of this policy is made easily available upon your request.

1. **Insurance.** We participate with most insurance plans, including Medicare. If you are not insured with a plan that we are currently in network with, payment is expected in full at the time services are rendered. If you are insured with an insurance plan that we are in network with, but do not have an up to date insurance card, payment is expected in full at the times services are rendered. Once your current insurance information is given to us and we are able to submit a claim for reimbursement, we will promptly reimburse any amount that which exceeds the reimbursement.
2. **Co-payments and deductibles.** All co-payments must be paid PRIOR to being seen by our medical provider. Deductibles may be collected at the time service is rendered or after we receive and explanation of benefits from your insurance carrier. This arrangement is part of your insurance contract with your insurance company. As a courtesy, in some circumstances with may bill you for this payment if not able to be fulfilled on the date of service.
3. **Non-covered services.** Please be aware that some and perhaps all of the services you receive mat not be considered reasonable or necessary by Medicare or other insurance providers. On the chance of this happening, or if the service is not an including benefit, you will be responsible for the service in full.
4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.
5. **Claim submissions.** We will submit your claims and assist you in any way we reasonable can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not you insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company, and we are not party to that contract.
6. **Coverage changes.** If your insurance changes, please notify us before you next visit so we can make the appropriate changes to help you receive your maximum benefits. If we are not supplied with this information and your claim is denied, then the balance will be billed to you.
7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter from us notifying you that if you do not pay your balance it will be turned over to collections. At this time, you will need to contact our office and make a payment. If a payment plan is agreed upon, you must supply us with a credit card to keep on file to process the payments. On the day of making the arrangements your credit card will be charged a minimum of $1 to verify the card is active.

Our practice is committed to providing the best treatments to our patients. Our prices are representative of the usual and customary charge for our area. Thank you for understanding our payment policy. Please let us know if you have any questions of concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

X SIGNATURE: _____ ***Date:*** _____

NOTICE OF PRIVACY PRACTICES

Request restrictions

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment and healthcare operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. For example, you could ask that we not disclose any information about a surgery you had. Any request for a restriction must be sent in writing to the facility privacy official. We are required to agree with your request only if i) except as otherwise required by law, the disclosure to your health plan and the purpose is related to payment or healthcare operations (and not for treatment purposes), and ii) our information pertains solely to health care services for which have been paid in full. **For other requests, we are not required to agree.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

Request confidential communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work instead of your home. The facility will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive your bills for services rendered by the facility and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communications from us that require a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

A paper copy of this notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

Changes to this notice

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you, as well as any information we receive in the future. The current notice will be posted in the facility and on our website and include the effective date. In addition, each time you register or are admitted to the facility for treatment or healthcare services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the facility by following the process outlined in the facility's Patient Rights documentation. You may also file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other uses of health information

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us permission to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we provided to you.

Questions about your rights

If you have any questions or concerns about any rights mentioned in our policies you make contact our privacy officer, Morgan Vernoy, or the current privacy officer at our facility. Our contact information: Martinez Urgent Care, Inc., 210 Bobby Jones Expressway, Martinez, Georgia 30907, P) 706-855-1755, F) 706-863-2587, martinezurgentcare@hotmail.com

X Signature: _____ ***Date:*** _____

Questions about your rights

I hereby acknowledge that Martinez Urgent Care, Inc. has provided me with access to it Notice of Privacy Practices, version effective October 20, 2015, as required by the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). I further acknowledge that Martinez Urgent Care, Inc. has offered to me and will, upon my request, provide me with a hard copy of its Notice of Privacy Practices. I consent to the uses and disclosures of my health information as outlined in the Notice.

X Signature: _____ ***Date:*** _____

Printed Name: _____ ***Date of Birth:*** _____