URGENT CARE
OF HANFORD

1028 N. DOUTY ST., STE #1
HANFORD, CA 93230

TEL: 559-530-2526
FAX: 559-410-8215

PATIENT INFORMATION

PATIENT FIRST NAME: | INITIAL: | LAST NAME: | DATE OF BIRTH:

STREET ADDRESS: | APT #: | CITY: | STATE: | ZIP:

CELL #: | HOME #: | SOCIAL SECURITY #: (REQUIRED)

EMAIL ADDRESS: | PRIMARY CARE PHYSICIAN:

OCCUPATION: | EMPLOYER: | WORK PHONE:

EMERGENCY CONTACT

CONTACT'S NAME:

RELATIONSHIP:

CONTACT'S PHONE NUMBER:

WHO OR WHAT MAY WE THANK FOR THIS REFERRAL?

☐ DRIVE BY SIGNAGE ☐ FAMILY OR FRIEND ☐ PHYSICIAN ☐ INSURANCE COMPANY ☐ INTERNET ☐ OTHER

RESPONSIBLE PARTY/GUARANTOR (Insurance holder for patients under 18 years of age)

LAST NAME: | FIRST NAME: | DATE OF BIRTH:

STREET ADDRESS: | APT #: | CITY: | STATE: | ZIP:

PHONE #: | SOCIAL SECURITY #: (REQUIRED) | RELATIONSHIP TO PATIENT

INSURANCE INFORMATION

☐ SELF PAY/NO INSURANCE
☐ SELF PAY/DO NOT BILL INSURANCE
☐ CARD PROVIDED
☐ SECONDARY INSURANCE COMPANY

PRIMARY INSURANCE COMPANY:
ID NUMBER:
GROUP #:

SECONDARY INSURANCE COMPANY:
ID NUMBER:
GROUP #:

VERIFICATION OF INFORMATION/HIPAA NOTICE OF PRIVACY

I verify that the above information provided is true and correct to the best of my knowledge. I hereby authorize the facility to accept assignment of insurance benefits and I understand that I am responsible for co-insurance, co-payments, and/or deductibles at the time of service. I understand that if my insurance is a non-contracted plan (out of network); the facility will courtesy file the claim for services rendered. In the event that I have no insurance coverage, I understand that the fees are due at the time of service. I understand that the previous balances owed to the facility will be requested at the time of registration.

The signature below is only acknowledgement that you have received the Notice of our Privacy Practices.

AUTHORIZED SIGNATURE OF PATIENT/GUARDIAN/ACCOMPANYING ADULT | DATE

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CONSENT FOR TREATMENT

I hereby consent to medical evaluation, testing, and/or treatment provided to me by the staff of this facility which may also include medical and minor surgical treatment or procedures, emergency treatment, and laboratory procedures. I understand that this medical facility may use or disclose Protected Health Information (PHI) necessary to carry out treatment, payment, or healthcare operation. I authorize release of any information concerning me or my child's healthcare, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize the facility to e-prescribe my prescriptions. For treatment purposes, the facility may request and utilize my medication history from other healthcare providers or third party pharmacy benefit payers. I acknowledge that if the provider has ordered additional laboratory testing that the collected specimens will be sent to a local laboratory for testing. (The facility will forward your payer information to the laboratory but you will be responsible for the charges incurred for these services and will receive a separate bill from the laboratory.)

I understand that there may be a portion of the cost of Durable Medical Equipment that is not covered by my insurance and I will be responsible for the balance. Please notify staff of any barrier to effective communication or educational instruction that would prevent the understanding of information about the patient's health status, treatment, or the informed decision making process, such as foreign language, hearing or speech impairment, difficulty with reading or writing, or inability to comprehend verbal instruction.

AUTHORIZED SIGNATURE OF PATIENT/GUARDIAN/ACCOMPANYING ADULT	DATE

WAIVER OF LIABILITY FORM

PROVIDER: This form is to be used for PPO, HMO and MEDICARE members who wish to receive health care services from Central Coast Urgent Care, Inc., in Atascadero, Morro Bay, Pismo Beach and Urgent Care of Hanford, that may not be covered by their PPO, HMO, Kaiser, Tri-Care, and MEDICARE benefit plan.

MEMBER: Your signature on this form acknowledges that you agree to bear financial responsibility for any service† provided as listed below:

- The service is not covered under your benefit plan, or
- The service has not been otherwise approved for payment by your health plan, or
- The service is not medically necessary, or
- The service is primarily for comfort and convenience, or
- You choose to upgrade a product or service above the level otherwise covered under your health plan you will pay the difference between the billed amount and allowed amount.

† *Service: Any service not described as a covered benefit in the members Evidence of Coverage Disclosure Form*

In addition to being responsible for the amount, I understand I will be billed and held responsible for any applicable co-payment of deductible. I understand I will be billed and held responsible for any applicable weekend, holiday and after hour charges not paid by my insurance.

PRINT NAME	SIGNATURE	DATE

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NEW PATIENT QUESTIONNAIRE FORM

PATIENT FIRST NAME: | INITIAL: | LAST NAME: | TODAY'S DATE:

DATE OF BIRTH: | AGE: | SEX: | OCCUPATION: | MARITAL STATUS:
☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOW

Chief Complaint (Why are you here?):

Duration (How long have you had this problem?):

What treatments have you attempted for this problem?

Preferred Pharmacy:

Have you previously or do you currently have any of the following?

YES	NO		YES	NO		YES	NO	
☐	☐	DIABETES	☐	☐	HYPERTENSION	☐	☐	ACUTE INFECTION
☐	☐	CANCER	☐	☐	STROKE	☐	☐	VENEREAL DISEASE
☐	☐	HEART TROUBLE	☐	☐	ARTHRITIS/GOUT	☐	☐	HEREDITARY DISEASE
☐	☐	CONVULSIONS	☐	☐	BLEEDING TENDENCY	☐	☐	OTHER_____

Previous Hospitalizations/Surgeries/Serious Injuries	Date

Are you allergic to any of the following?

☐ PENICILLIN ☐ MERCURY ☐ SULFA ☐ IODINE ☐ MYCINS ☐ TETANUS
☐ CODEINE ☐ ADHESIVE TAPE ☐ MORPHINE ☐ LATEX ☐ ASPIRIN ☐ COSMETICS

FOOD ALLERGIES: | OTHER:

DATE OF LAST TETANUS: | CURRENT MEDICATIONS:

Do you use any of the following?

Alcohol: ☐ NEVER ☐ RARELY ☐ MODERATELY
Tobacco: ☐ NEVER ☐ YES, _____ Packs/Day For _____ Years
Drugs: ☐ NEVER ☐ YES, Type/Frequency _____

☐ QUIT
QUIT DATE:
_____

Family Medical History

	AGE	M OR F	DISEASES	DECEASED	CAUSE OF DEATH
Father	_____		_____	☐	_____
Mother	_____		_____	☐	_____
Siblings	_____	_____	_____	☐	_____
	_____	_____	_____	☐	_____
Children	_____	_____	_____	☐	_____
	_____	_____	_____	☐	_____

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.
THIS STATEMENT ALSO DESCRIBES HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information, that may identify you and that relate to your past, present, and/or future physical or mental health or condition or related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff, and others outside our office. Health information may be used in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice. and any other use required by law.

TREATMENT

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has necessary information to diagnose or treat you.

PAYMENT

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for hospital admission.

HEALTHCARE OPERATIONS

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students who see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include but are not limited to: (as) Required by Law, Public Health issues required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration Requirements: Legal Proceeding: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Service to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, Authorization or Opportunity to object unless required by law.

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HIPAA NOTICE OF PRIVACY PRACTICES – PAGE 2

You may revoke to this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use of disclosure indicated in the authorization.

YOUR RIGHTS

Following is a statement of your rights with respect to protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect the copy of the following records: psychotherapy notes: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment of healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must states the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You may have the right to have your physician amend our protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

You may complain to the Secretary of Health and Human Services or us if you believe you privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate again you for filing a complaint.**

We are required by law to maintain the privacy of and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak without HIPAA Compliance Officer in person or by phone at our main phone number.

This notice was published and became effective on/or before April 14, 2003.

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OFFICE POLICIES

1. This office reserves the right to refuse service to anyone.

2. Please DO NOT bring food, drinks or pets into the building.

3. This office does not write prescriptions for chronic pain.

4. If you are using medical insurance you must provide legal photo identification.

5. All forms or payment including private payment and co-payment are collected prior to being seen by the provider.

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