Health First
URGENT CARE

PATIENT INFORMATION

Name: _____ **Date:** _____/_____/_____
Last First MI

DOB: _____/_____/_____ **SSN:** _____-_____-_____ **Age:** _____ **Sex:** ☐ **M** ☐ **F**

Address: _____
Street Apt # City State Zip

Home Phone (____)_____ **Cell Phone** (____)_____ **Work Phone** (____)_____
☐ Yes, messages can be left at this number. ☐ Yes, messages can be left at this number. ☐ Yes, messages can be left at this number.

Which would you prefer we call? ☐ Home ☐ Cell ☐ Work **Email:**_____

Emergency Contact: _____
Name Phone Relationship

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

If you would like to authorize Health First Urgent Care to release information regarding your medical care and/or laboratory results to someone in addition to yourself (spouse, parent, etc.) please list name below: If not, please check the box below:

☐ **Please do not disclose information to anyone but myself**

_____ _____
Name **Relationship**

PRIMARY INSURANCE INFORMATION

Insurance Company _____ Benefit Phone _____

Subsciber ID # _____ Group # _____

SECONDARY INSURANCE INFORMATION

Insurance Company _____ Benefit Phone _____

Subsciber ID # _____ Group # _____

INSURANCE POLICY HOLDER (IF DIFFERENT FROM PATIENT)

Print Name as it appears on your insurance card:

Name: _____ **DOB** _____/_____/_____
Last First MI

Address: _____
Street Apt # City State Zip

Contact Number (____)_____ **Relationship to Patient:** _____

I have read all of the above information and have completed it to the best of my knowledge. I will notify you of any changes in my health status or demographic information. I hereby authorize Health First Urgent Care to furnish information to insurance carriers concerning my medical status. I understand that I am responsible for any amount not covered by my insurance.

_____ _____
Signature of Patient/Guardian **Date**

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URGENT CARE

HEALTH QUESTIONNAIRE

Name: _____ **Birth Date**: ____/_____/_____ **Date**: ____/_____/_____
Last First MI

Gender: ☐ Male ☐ Female, if yes : ☐ Pregnant? ☐ Breastfeeding?

Reason for visit today? _____

List all your current medications, including non-prescription drugs: ☐ None _____

_____

Medication Allergies: ☐ No known allergies _____

PAST MEDICAL HISTORY (Check all that apply & Specify) ☐ NONE APPLY

☐ Allergies _____
☐ Anxiety_____
☐ Asthma_____
☐ Arthritis_____
☐ Cancer _____
☐ Depression_____
☐ Diabetes (type)_____
☐ Emphysema/COPD_____
☐ Epilepsy/Seizure Disorder _____
☐ Headaches_____
☐ Heart Disease _____
☐ High Blood Pressure _____
☐ High Cholesterol_____
☐ Kidney Disease_____
☐ Liver Disease_____
☐ Stroke_____
☐ Thyroid Disease_____
☐ Other (specify)_____

HOSPITALIZATION & SURGERY (Check all that apply, specify and write in date below) ☐ NONE APPLY

☐ Appendix _____
☐ Adenoids _____
☐ Back _____
☐ Breast _____
☐ Heart Surgery _____
☐ Hernia _____
☐ Hysterectomy _____
☐ Tonsillectomy _____
☐ Tubal Ligation _____
☐ Vasectomy _____
☐ C-Section _____
☐ Other (specify)_____

FAMILY HISTORY (Check all that apply & specify) ☐ NONE APPLY

☐ Asthma _____
☐ Cancer (specify) _____
☐ Dementia/Alzheimer's _____
☐ Depression _____
☐ Diabetes_____
☐ Heart Disease _____
☐ High Blood Pressure _____
☐ High Cholesterol _____
☐ Stroke_____
☐ Thyroid Disease_____
☐ C-Section _____
☐ Other _____

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you smoke? ☐ No ☐ Yes _____ packs/day

Do you drink alcoholic beverages? ☐ No ☐ Yes

For the MINOR patient:

Child lives with: ☐ Parents ☐ Grandparents

☐ Other _____

Do you use any recreational drugs or medications not prescribed to you? ☐ No ☐ Yes, _____

I have read the above information and consent that it is correct to the best of my knowledge. I authorize Health First Urgent Care and its health care providers to render necessary treatment for my condition.

_____ _____
Signature of Patient/Guardian **Date**

This form has been reviewed by the treating physician:

_____ _____
Signature of Physician **Date**

888 S. Greenfield Rd. Ste. 101 Gilbert, AZ 85296
Phone: (480) 892-1300 Fax: (480) 507-7477
Dr. Brenden McRae, MD

PAYMENT POLICY

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate in, payment in full is expected at each visit. If you are insured by a plan we participate in but do not have a current insurance card, payment in full for each visit is required until we can verify your coverage. When insurance is involved, we can file claims on your behalf in most cases. At times however, a portion of care is paid by the patient based on your specific plan. We will bill the responsible party for those services clearly outlined by the insurance plan that are the patients responsibility. Knowing your insurance benefits is your right and responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-Payments.** All co-payments must be paid at the time of service. This arrangement is part of our contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-Covered Services.** Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full whether at the time of your visit or herafter.

4. **Proof of Insurance.** All patients must complete our patient information forms before seeing the doctor. We must obtain a copy of your photo ID and a valid current 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 your claim.

5. **Claims Submission.** We will submit your claims and assist you in any reasonable way 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 requests. The amount owed to the office as outlined in your insurance contract is your responsibility.

6. **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. **Financial Policy.** We are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and understanding of our payment policy. Co-payments and fees that you are responsible for are due in full at the time of service. Should the account become delinquent, your account will be referred to a collections agency and you will be responsible for those fees. In this case, you may be asked to seek treatment elsewhere until your account is reconciled. Acceptable forms of payment are cash, Visa, MasterCard, Discover or American Express.

By signing below you agree that you have read and understand the above information and comply with these policies.

_____ _____

Signature of Patient or Representative **Date**

Name (Please Print): _____ **DOB**: _____/_____/_____ **Date**: _____/_____/_____

NOTICE OF PRIVACY POLICIES

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. There are certain circumstances that require us to use or disclose your health information. Some of these circumstances are: **to public health authorities, lawsuits, law enforcement officials, federal officials, correctional institutions, military officials (for members of the military only), Workers Compensation and Health Insurance programs**.

You have rights regarding your health care and information. These rights include but are not limited to: communication regarding your healthcare, inspection of any health information or medical records (including billing records but not including psychotherapy notes), requesting amendments to health information, filing complaints against privacy, written consent and authorization to disclose any health or personal information to certain individuals. If you have any questions regarding this notice or our health information privacy policies please contact a member of our staff.

***A full copy of our privacy policy is provided upon request.**

I have read and understand the copy of Privacy Policies provided on this clipboard. Initials: _____

HIPAA

Health First Urgent Care upholds the standards of the HIPAA laws. As a patient, we want you to know:

- We respect the privacy of your personal medical records and will do all we can to secure and protect that privacy.
- When it is appropriate and necessary, we provide the minimum necessary information to only those individuals required by law or who we feel are in need of your health care information and information about treatment, payment or health care operations in order to provide health care that is in your best interest.
- You may refuse consent to use or disclosure your personal health information, but this must be in *writing*.
- You have the right and we agree to provide you with access to your medical records in accordance with state and federal laws.

***A full copy of our HIPAA policy is provided upon request.**

I have read and understand the copy of HIPAA Policies provided on this clipboard. Initials: _____

***If you have any questions regarding this content, please speak with a member of the staff of Health First Urgent Care.**