HEADLAND URGENT CARE

Patient Registration Form

Is this a work related injury visit? (Circle YES or NO)
If yes, please see front desk for correct paperwork.

Reason for visit: _____ Date: _____

Was this the result of a motor vehicle accident? Circle Yes or No

PATIENT INFORMATION:

Name:

Date of Birth: SS#:

Mailing Address: Apt#:

City: State: Zip:

Home Ph#: Cell Ph#:

Email:

Male: □ Female: □ Marital Status: _____

Primary Care Physician (PCP) : _____

PCP Phone #: _____

Pharmacy Name: _____

Pharmacy Address/Location:

_____

Pharmacy Telephone:

_____

EMERGENCY CONTACT INFORMATION:

Name:

Relationship:

Home Ph#:

Cell Ph#:

Based on government regulations, we are required to ask the following:

What is your preferred language:

Race: ☐ I prefer not to answer

Ethnicity: ☐ I prefer not to answer

Best Form of Contact: ☐ Cell ☐ Home ☐ Email ☐ Mail

Best Time to Call: May we leave a message? ☐ Yes ☐ No

INSURANCE INFORMATION: Primary Ins: _____

Contract #: _____ Group #: _____

Name of Insured:

Date of Birth:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Secondary Ins: Ins #:

Name of Insured:

Date of Birth:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFITS

☐ Check if same as patient information. If not, please complete the entire section.

Name: ☐ Male ☐ Female

Date of Birth: SS#:

Relationship:

Phone #:

I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office are due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefits to this office. In the event my account is turned over to a collection agency, I agree to pay all costs of collection fees and/or attorney's fees and all court costs if any. I agree to be contacted at any telephone number or email address associated with my account. This includes cellular telephone numbers or other wireless devices. understand this could result in a charge from my phone or device carrier to me for talk time, SMS messaging/texts or data usage for emails or voice mails. I also understand methods of contact may include pre-recorded /artificial voice messages and/or the use of automatic dialing devices as applicable.

Signature

CONSENT FOR TREATMENT

I, the undersigned, consent to the care and treatment by the attending Physician, his/her associates or assistants and acknowledge that no guarantees have been made as to the effect of such treatment.

Date

NOTICE OF PRIVACY PRACTICES

I have reviewed the Notice of Privacy Practices as provided at registration and understand that I may request a copy of the policy at any time.

Signature

HEADLAND
URGENT CARE

FINANCIAL AGREEMENT

You expressly consent and agree that, in order to discuss or service your accounts(s) (the "Accounts ") or to collect amounts you may owe, Headland Urgent Care LLC, and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively, "We") may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contact you by sending text messages, emails, using any e-mail address you provide to us, 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 the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

Signature of Patient or Guardian:_____Date:_____

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY/E-PRESCRIBING

E-Prescribing is defined as a physician's ability to electronically send an understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. By Headland Urgent Care LLC and its Affiliated Providers, you allow us to view your external prescription history via the RxHub service and PDMP. This will provide the physician with information about medications the patient is already taking to minimize the number of adverse drug events. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my provider and staff here, and it may include prescriptions back in time for several years. By signing this consent form you are agreeing that Headland Urgent Care and its Affiliated Providers can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

My signature certifies that I read and understood the scope of my consent and that I authorize the access.

_____ _____

Signature of Patient or Legal Guardian Date

MEDICAL INFORMATION RELEASE (HIPAA)

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

_____ and Relationship: _____

□ Information is not to be released to anyone

Signature of Patient or Legal Guardian: _____ Date:_____

***Adding Collection Fees To Account Balances: ***

AGREEMENT TO PAY: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State

*** Consent To Contact Debtors on Their Cell Phones: ***

SAMPLE DISCLOSURE LANGUAGE:
EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE:
You agree, in order for us to service your account or to collect monies you may owe, Headland Urgent Care and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We and/or our agents may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that, Headland Urgent Care, its employees, and/ or agents, .may contact me/us by any permissible method described above. You agree that any permissible contact may include the use of pre-recorded and/or artificial voice messages and/or the use of an automatic telephone dialing system.

_____ _____

Responsible Party Signature Date

Notice of Privacy Practices

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

We are required by law to maintain the privacy and security of your protected health information ("PHI"). We will let you know promptly if a breach occurs compromising the privacy or security of your information. We must follow the duties and privacy practices described in this notice, and we must furnish a copy of it to you. We will not use or share your PHI other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time by directing us in writing that we may no longer share your PHI in such way.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION.

A. Permissible Uses and Disclosures Without Authorization: We may use and share your PHI without your written authorization for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, only to describe the types of use and disclosures that are permissible under applicable law.

1. *Treatment*: We may use your PHI and share it with other professionals involved in your medical treatment. For example, when a doctor treating you for an injury asks another doctor about your overall health.

2. *Billing*: We may use and share your PHI to bill and collect payment from health plans, a guarantor or other appropriate persons or entities. For example, we give information about you to your health insurance plan so it will pay for services rendered to you.

3. *Health Care Operations*: We may use and share your PHI to run our business, improve your and others' care, and may contact you when necessary. We assess your treatment and our overall operational performance by soliciting patient feedback via text message. ***By signing this Notice, you consent to our delivery of one or more text messages for the purpose of assessing your treatment and overall patient experience. You may opt out of our text messages by checking here*** ☐ Once given, you may opt out at any time by responding to a text message or letting us know directly.

4. *Required or Permitted by Law*: We must make disclosures to you and others when required by applicable law.

5. *Public Good*: We may share PHI in certain situations generally involving the public good including (a) disease prevention, (b) product recalls, (c) reporting adverse reactions to medications, (d) reporting abuse, neglect, or domestic violence, or (e) preventing or reducing a serious threat to anyone's health or safety.

6. *Organ Donation*: We may share PHI with organ procurement organizations.

7. *Death-Related*: We may share PHI with a coroner, medical examiner, or funeral director when an individual dies.

8. *Workers' Comp/Law Enforcement*: We may use or share health information about you: (a) for workers' compensation claims, (b) for law enforcement purposes or with a law enforcement official, (c) with health oversight agencies for activities authorized by law, (d) for special government functions such as military, national security, and presidential protective services.

9. *Lawsuit*: We may share health information about you in response to a court or administrative order, or in response to a subpoena.

B. Permissible Uses and Disclosures Unless You Object: If you have a clear preference for how we share your information in the following situations, let us know. Tell us what you want us to do, and in nearly all circumstances, we will follow your instructions. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

1. *Family and Other Persons Involved in Your Care*. We may share your PHI with your family, close friends, or others involved in your care.

2. *Disaster Relief Efforts*. We may share your information in a disaster relief situation.

C. Uses and Disclosures With Your Authorization: We may use and disclosure your PHI for marketing or sale to third parties, but only with your authorization.

II. YOUR INDIVIDUAL RIGHTS.

A. Right to Inspect and Copy. You may ask to see or receive an electronic or paper copy of your medical record and other PHI we have about you. Ask us how to do this. We will provide a copy or a summary of your PHI, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

B. Right to Alternative Communications. You may ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

C. Right to Request Restrictions. You may ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to grant to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you may ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

D. Right to Accounting of Disclosures. You may ask for a list (accounting) of the times we've shared your PHI for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months

E. Right to Request Amendment: You may ask us to correct any aspect of your PHI that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days

F. Right to Obtain Notice. You have the right to obtain a paper copy of this Notice at any time even if you requested to receive it electronically.

G. Question and Complaints. If you desire further information about your privacy rights or are concerned that we have violated your privacy rights, you may contact the clinic's Practice Director in which you visited. You may file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you if you file a complaint.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE. This Notice is effective on July 9, 2018. We may change this Notice at any time. If we change this Notice, we may make the new terms effective for all PHI that we maintain, including any information in our possession prior to the effective date of the new notice. We post our current notice in the waiting area of our clinics and on our web site. You may always obtain our current notice by contacting one of our clinics.

I have reviewed this Notice and understand that I may request a copy of the policy as may be amended at any time.

SIGN NAME: _____ *(Patient, Parent or Guarantor)*

PRINT NAME: _____ **DATE:** _____

Name: _____DOB: _____Date:_____

Past Medical History

- ☐ NONE
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Clots
- ☐ Cancer
- ☐ CHF
- ☐ COPD
- ☐ Emphysema
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ Glaucoma
- ☐ GERD
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Kidney Disease
- ☐ Mental Illness
- ☐ Migraines
- ☐ Obesity
- ☐ Peripheral Artery Disease
- ☐ Osteoporosis
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ STD
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ TIA
- ☐ Other_____

Give Date of Last: Menstrual period_____, Chemotherapy_____, Radiation_____

Surgical History

- ☐ NONE
- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Bone Surgery
- ☐ Brain Surgery
- ☐ Cesarean Section
- ☐ Coronary Artery Graft
- ☐ Eyes
- ☐ Gallbladder
- ☐ Gastric Bypass
- ☐ Heart Stent
- ☐ Hysterectomy, Abdominal
- ☐ Inguinal Hernia Repair
- ☐ Intestinal/Rectal Surgery
- ☐ Knee Surgery
- ☐ Lung Surgery
- ☐ Mastectomy, Left
- ☐ Mastectomy, Right
- ☐ Neck Surgery
- ☐ Pacemaker, Cardiac
- ☐ Sinus surgery
- ☐ Splenectomy
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Transplant
- ☐ Wisdom Teeth
- ☐ Other_____

Family History

Does your Father have: Living:_____Deceased:_____Cause of Death_____

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Cancer/TYPE:_____
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney disease
- ☐ Mental Disease
- ☐ Thyroid Disease
- ☐ Seizure
- ☐ Stroke
- ☐ Mental Illness
- ☐ Other_____

Does your Mother have: Living:_____Deceased:_____Cause of Death_____

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney disease
- ☐ Mental Disease
- ☐ Thyroid Disease
- ☐ Seizure
- ☐ Stroke
- ☐ Mental Illness
- ☐ Other_____

Do your Children or Siblings have - Please specify:

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney disease
- ☐ Mental Disease
- ☐ Thyroid Disease
- ☐ Seizure
- ☐ Stroke
- ☐ Mental Illness
- ☐ Other_____

Social History

- * **Tobacco Status:** ☐ Current Smoker ☐ Former Smoker ☐ Never Smoked Packs Per Day _____
- * **Alcohol Drinks:** ☐ Daily ☐ Weekly ☐ Monthly ☐ Never
- * **Illegal Drug Use** ☐ Never used ☐ Former User ☐ Current User

Current Medications (Please attach form if needed)	Dose	Frequency

Drug Allergies	Reaction

Patient Signature:_____

Name: _____DOB: _____Date:_____