westview URGENT CARE MED CENTER

CHART#: **ESTABLISHED PATIENT** ROOM#:

Patient Name:____ **D.O.B** ___/___/_____

Reason for your visit today:_______________________________ **Date** ___/___/_____

CHECK ALL THAT APPLY TO TODAY'S VISIT

Is this the result of an auto accident? __No __Yes **Did this happen at work?** __No __Yes

Constitutional
__weight loss
__fatigue
__fever

Eyes
__eye pain
__blurry vision

Ear, Nose, Throat
__difficulty hearing
__ringing in ears
__dizziness
__nasal congestion
__sore throat

Cardiovascular
__chest pain
__palpitations
__fainting spells
__shortness of breath
__swollen ankles

Endocrine
__excessive hair loss
__heat/cold intolerance

Respiratory
__cough
__coughing up blood
__wheezing
__ chills

Gastrointestinal
__heartburn
__nausea/vomiting
__constipation
__diarrhea
__abdominal pain
__black/bloody stool

Genitourinary
__burning/frequency
__blood in urine
__abnormal discharge
__bladder leakage

Allergic/ Immunologic
__hives
__eczema
__hay fever

Psychiatric
__anxiety
__depression
__mood swings
__difficulty sleeping

Hematology/Lymph
__easy bruising
__gum or nose bleeds
__enlarged glands

Musculoskeletal
__joint pain/swelling
__joint stiffness
__muscle pain
__back pain

Skin
__rash/ sores
__skin lesions

Neurological
__loss of strength
__numbness
__headache
__tremors
__memory loss

Past Medical History ***PLEASE ANSWER ALL FIELDS 1-7 (if does not apply, please check appropriate option or write N/A)***

1) ___No past Medical History __Asthma/COPD __Diabetes __Hypertension __Heart Disease __Stroke __Cancer __Sinusitis __Migraines __Seasonal Allergies __Seizures __Thyroid __Arthritis __HIV/AIDS __Anxiety __Depression __Hepatitis
Other:____

2) Past Surgical History: ____ No Past Surgical History ______________________________ __________________________

3) Alcohol use: __Never __Social __Regular Smoking: __No __Yes ___packs/day Illicit **Drugs**: __No __Yes **Occupation**: __________

4) Family History: ____No Past Family History __Hypertension __Heart Disease __Diabetes __Cancer __Asthma

5) Drug Allergies: __None __Penicillin __Sulfa __Codeine __Aspirin __Latex __Iodine Other: ________________

6) Current Medications: ____

Birth Control: __No __Yes **Pharmacy**:_______________________________________**phone**:_______________

Signature:____ **Date**___/___/____

BP:

PULSE:

SPO2:

TEMP:

RR:.

HT:

WT:

L

Financial Policy

We hope to make your visits in our office as thorough and pleasant as possible. We also want you to have a full understanding of our financial policies and expectations for payment for services. Please carefully review and sign our financial policy, and let us know of any questions you may have.

The primary and final relationship is between the medical provider(s) at Westview Urgent Care and you (the patient) and our contract is with you. We will not compromise your medical care to satisfy ANY insurance company. Bear in mind, insurance is meant to help defray the cost of medical care and is NOT intended to dictate your treatment.

Payment is due and expected in full at the time services are rendered. This includes deductibles, co-payments, co-insurances and non-covered services.

As a courtesy we are happy to assist you in the filing of your insurance claims, completing insurance forms, and insurance pre-certification. You will be responsible for any and all balances not covered by your insurance. As the insured client, you are in the best position to follow up and exert pressure on your insurance carrier to ensure payment is being processed.

You will receive a monthly statement requesting payment of any unpaid balance. If your account becomes past due, please contact our office to discuss payment arrangements and avoid further collection efforts. We are committed to being sensitive to patient financial difficulties, but we are unable to assist if you do not contact us to discuss your account.

Any balance that is over 90 days old will be subject to be sent to Valley Credit Services for collections.
If my account becomes assigned to a collection agency, I agree to pay a 25% collection fee, interest in the amount of 20%, court costs, and attorney's fees, as allowed by law.

There is a fee (currently $35) for any checks returned by the bank.

We are here to serve your health needs and will work hard on your behalf, to contain fees and other charges while providing you with quality health care.

I have read and understand the above policies. I understand that I may receive a copy of this form upon request.

Assignment of Insurance Benefits

I authorize my insurance benefits to be paid directly to Westview MediCenter..

I also authorize Westview MediCenter to release any medical and/or personal information required by my insurance company(ies) in order to process my claims.

I have been made aware that after 6:00 p.m., weekends, and holidays my medical visit is subject to an after-hours charge.

I understand that if I am seen by the Medical Staff it is a billable office visit and any copays or deductible payments that were paid will not be refunded. The signed party recognizes that ultimately it is their responsibility to understand the terms of their insurance.

Print Name:_____________________

ADDRESS:____________________________________ Phone #: _______________

X_____________________________________ __________________

Patient Signature OR Parent/Guardian Signature **Date**