Please Print Clearly **Today's Date _____________**

Patient Information

Last Name:___________________________First Name:____________________Middle Int: ___ Nickname:___________________

Address: _______________________________City:_______________ ______State:_____________Zip:_______________

Home Phone:_____________________ Work:___________________Ext:_______ _Cell:_____________________________

LAST 4 SS#: -___________ Sex: ___ M___ F Marital Status:______________ Date of Birth:___/____/_____

Email Address: ________________________________ How you like to be contacted: ______________________

Family Doctor: ________________________________ phone#_______________________

Emergency Contact*-please list an alternative contact if we are unable to contact you*

Name:________________________________ Phone _______________________ Relationship:______________

Demographic Information

Race: __American Indian __African American __Hispanic/Latino __Caucasian __Asian __Decline
Ethnicity: __Hispanic/Latino __Not Hispanic/Latino __Decline
Preferred Language:_________________________________

Parent or Legal Guardian (for patients under 18)***

Name:__________________________________Date of Birth:____/_____/_____ Relationship to Patient: ___________________

Address: ____________________________________City:_______________ ______State:________Zip:_____________________

Same address at patient____

Primary Insurance Information

Insurance Company:_________________________Member #: ____________________Group#____________________

Policy Holder's Name:___________________________Date of Birth_____/_____/_______Relationship to patient:_________________

Address (if different from patient):______________________________City:__________Zip:__________Phone #:________________

Secondary Insurance Information

Insurance Company:_________________________Member #: ____________________Group#__________________________

Subscriber's Name:__________________________Date of Birth_____/_____/_______Relationship to patient:_________________

Address (if different from patient):______________________________City:__________Zip:__________Phone #:________________

NOTE
The parent or legal guardian who brings the child in to be seen for medical treatment is responsible AT THE TIME OF SERVICE for any co-payments, deductibles and account balance.

NOTICE OF PRIVACY PRACTICES

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The type of information may include, but is not limited to: Physician Dictation, Laboratory Results, Consultation Reports, Surgery/Pathology, Diagnostic Test Results, Pharmacy Records, and Communication with the Pharmacy.
3. I understand that the information in my health record may include information relating to sexually transmitted disease, Acquired Immunodeficiency syndrome (AIDS), or Human Immunodeficiency Syndrome (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol and drug abuse.
4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and discuss your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or payment for you healthcare, but only if you agree that we may do so.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

I authorize Westview Urgent Care staff to leave voice mail messages about my care at Westview. If you do *not* authorize this, please give specific instructions for disclosure of your information in the space below.

By signing the below line I acknowledge that I have read and understand the above waiver & that all information provided is accurate.

X____ ______________________

Patient Signature OR
Parent/Guardian Signature (if under 18)

Date

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.

X____ ____________________

Patient Signature OR **Date**
Parent/Guardian Signature (if under 18)

CHART#: **NEW PATIENT** ROOM#:

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

Reason for your visit today:_______________________________________ **Date** ___/___/______

CHECK ALL THAT APPLY TO TODAY'S VISIT:

7) 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 **Illict 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:

LMP: