Eastern Shore Urgent Care

29710 Urgent Care Drive
Daphne, Alabama 36532
Phone (251) 626-3782 * Fax (251) 626-0787

**** This information is updated yearly for office purposes****

Patients Legal Name_____ /_____ /____ / _____ /_____

Last **First** **MI**

Maiden Name **Preferred Name**

DOB_____ **Age** _____ **SSN**_____**Gender**_____**DL #**_____**State**_____

Mailing Address_____ **Apt #**_____ **City**_____ **State** _____ **Zip**_____

Primary Phone No. (____) _____ **Cell No.** (____) _____ **Marital Status: S__ M__ D__ W__ Other**_____

Patient's Email_____ **Pharmacy** _____

Patient's Employer _____ **Phone No.** (_____) _____

Spouse's Name _____ **SSN** _____ **DOB** _____

Spouse's Employer Phone No. (_____) _____ **Spouse's Cell No**. (_____) _____

Emergency Contact _____ **Relationship** _____ **Phone No**. (_____) _____
(*If other than spouse)

INSURANCE INFORMATION:

1st Insurance Company _____ **Member/ Contract No.** _____ **Group No.** _____

2nd Insurance Company _____ **Member/ Contract No.** _____ **Group No.** _____

*****RESPONSIBLE PARTY INFORMATION (This is the person who has the insurance, if other than the patient.)*****

1. Name _____ **Phone No.** (_____) _____

Date of Birth _____ **SSN** _____ **Relationship to Patient** _____

2. Name _____ **Phone No.** (_____) _____

Date of Birth _____ **SSN** _____ **Relationship to Patient** _____

Eastern Shore Urgent Care does not provide chronic pain management, refills of controlled medications, treatment of depression, anxiety, panic attacks or ADHD. We do not provide sexually transmitted disease screening in asymptomatic patients, treatment of sexual dysfunction or sexual assault. Our staff will provide referrals if requested.

I authorize the release of any information concerning my (or my child's) healthcare and treatment for the purposes of evaluating and administering claims of insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me directly, to the Physician. (We will file a claim with your insurance company for services provided. In the event of non-payment, you will be responsible for the charges incurred today.)

Signature (patient or parent/guardian) _____**Date** _____ /_____ /_____

Eastern Shore URGENT CARE CENTER

Patients Name_____ Date _____ /_____ /_____

I authorize Eastern Shore Urgent Care and/or its representatives to contact me in reference to any items that will assist the practice in providing optimal care such as insurance items and any information pertaining to my clinical care (including laboratory results and x-rays). I authorize the following methods of communication for the items listed above:

__Mail __E-mail __Home Telephone __Cell Phone/Text __Voicemail/Answering Machine

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With my consent, all financial and/or medical information can be given to the following people:

_____ _____

_____

Name Relationship
Phone Number

(Circle all that apply) FINANCIAL MEDICAL

_____ _____

_____

Name Relationship
Phone Number

(Circle all that apply) FINANCIAL MEDICAL

_____ _____

_____

Name Relationship
Phone Number

(Circle all that apply) FINANCIAL MEDICAL

By signing below, I understand that I am allowing Eastern Shore Urgent Care's staff to speak to the above identified person(s) in reference to any and all of the Personal Health Information (PHI). I also understand that I can change this list at any time by appearing in person or in writing by sending a request to the office of:

Eastern Shore Urgent Care
29710 Urgent Care Drive
Daphne, Al 36526

_____

_____

Patient Signature (if 14 and older) **Legal Guardian Signature**

Financial Policy

Thank you for choosing Eastern Shore Urgent Care. We would like to provide the best care possible to you. **Please understand payment for our services is part of your treatment and care, and this statement explains our policies and procedures in that endeavor. Knowledge of your individual insurance plan coverage remains your responsibility, therefore we urge you, as a patient to check with your insurance company prior to any testing or procedures to be performed.**

Our practice policy requires that prior to any services being rendered; all patients must sign the practice financial and termination of care policy. We ask that you please present to the office with a form of payment to meet your obligations of your insurance provider and of your healthcare provider. We thank you in advance for taking the time to review these policies. Please feel free to discuss any concerns or questions you may have with our billing staff or our practice manager. We would welcome the opportunity to assist you in your understanding of the complexities of health insurance today.

We require the following before we can provide you care and treatment: (Please note; if you are unable to provide the following requirements at the time of your visit, you will be asked to pay for your visit as a Cash Pay Patient. **We do NOT bill Co-Pays'**)

- **Updated demographic, current insurance information, and driver's license**
- **Co-payment or payment for non-covered services**
- **Payment for services not filed on your insurance**
- **Referral if required by your insurance plan**

Termination of Care Policy

Eastern Shore Urgent Care reserves the right to dismiss a patient for the following reasons:

- **Failure to pay for services in a timely manner (refer to Financial Policy)**
- **Noncompliance with the conduct and service policies.**

Conduct /Behavior and Method of Contact Policy

We at Eastern Shore Urgent Care strive to provide an environment of excellence and professionalism in the best possible manner. Therefore, in order to ensure that everyone feels comfortable, we expect all of our valued patients to be mindful of their conduct. Any inappropriate language, loud conversation or disrespectful demeanor towards our staff will not be tolerated.

We value our patients and will try our best to service your needs. However, contacting physicians and staff outside of normal business hours, and attempting to contact them at their personal residence or personal phone numbers will not be tolerated. If you have an emergency, please visit your nearest emergency room at your earliest convenience. **I acknowledge Eastern Shore Urgent Care's Financial and Termination of care policies and I agree to comply with said policies set forth accordingly.**

Patient/Guardian Signature_____ Patient's Printed Name_____Date__/__/__

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment. We may use and disclose medical information about you so that treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: We may disclose your record to an insurance company so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the Practice or the hospital. For example, we may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts. WHO WILL FOLLOW THIS NOTICE. This notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the Practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records on your care generated by the Practice, whether made by Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include; appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in very limited circumstances.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

Right to Request Removal from Fundraising Communications. You have the right to opt out of receiving fundraising communications from the Practice.

Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing, and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the Practice's waiting room. COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact VaLonne Harmon, Privacy Officer, 251-380-8634, 29710 Urgent Care Drive, Daphne, AL 36526. All complaints must be in writing. You will not be penalized for filing a complaint. OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have questions about this notice or would like a more detailed explanation, please contact our Privacy Officer.

I acknowledge by signing that I have received the Notice of Privacy Practices and Notice of Individual Rights

_____ _____

Patient or Patient's Personal Representative Date