Nebraska Urgent Care Center

Today's Date:_____**Primary Care Dr**:_____**Pharmacy**:_____

Patient Name:_____ **Social Security #**:_____

Date of Birth:_____**Marital Status**: Married Single Widowed Divorced

Home Address:_____

Email Address:_____ **Phone #**: _____

Employer Name:_____**Work phone #**:_____**Job Title**:_____

Responsible Party (person responsible for paying bills):_____

Resp Party Address_____

Resp Party Phone #:_____**Resp Party Relationship to Patient**_____

Resp Party Date of Birth:_____**Resp Party Social Security #**:_____

Insurance carrier name: _____**Phone #**_____

Insurance carrier DOB:_____ **Social Security #**_____

Insurance carrier address:_____

Insurance carrier employer:_____**Employer's Phone #**:_____

Name of Primary Insurance:_____

Policy/Member ID #:_____**Group #**:_____

Emergency Contact (Not living in patient's home)_____

Address:_____**Phone #**_____

Relationship to patient: _____

How did you hear about us? Facebook Google search Friend/Family member other

Patient's Name:_____**DOB**:_____

Reason for visit today:_____

Substance use history:

Tobacco use (smoke, vape, or chew)?: **YES/NO**

If yes, how many pack per day?_____ _____

Alcohol Use: **YES/NO**

If alcohol use, how many drinks per week?_____

Illegal drug use (past or present)? **YES/NO**

Allergies:

_____

_____

_____

Immunizations up to date?

YES/NO

Prescribed medications, vitamins, or supplements:

_____

_____

_____

_____

Prior Surgeries:

_____

_____

_____

_____

Personal Medical History (EX:high blood pressure, thyroid disease)

_____

_____

_____

_____

Family health history:

_____

_____

_____

Consent to Treat

I hereby authorize the provider(s) at Nebraska Urgent Care & Family Practice Center to treat my condition(s) (or the patient's condition(s) if the person authorizing care is not the patient) as the provider(s) deem necessary and/or appropriate in the current situation. The provider(s) will explain any procedure(s) or treatment option(s) to me and/or a person authorized on my behalf to give consent, prior to any procedure(s) or treatment(s) being done here at Nebraska Urgent Care & Family Practice Center. I, as the patient/responsible party, have the right to refuse any procedure(s), treatment(s), and medication administration etc., at any time during my visit.

Release of Information

By signing this form, I authorize Nebraska Urgent Care & Family Practice Center and its staff to use and disclose the protected health information described below, to the individuals named. These individuals may also pick up prescriptions, samples, medical records and other health related items on my behalf. If the patient is a minor, please list parents' names below.

What level of information can we release?

- All information including specific information, related to lab results, test results, medications, allergies, etc.
- All information except _____
- **No information whatsoever**

To whom can we release information?

- _____ Phone #_____
- _____ Phone # _____
- _____ Phone # _____
- **No one except to the patient**

Persons authorized by responsible party to bring a minor patient in to be seen:

_____ _____

_____ _____

Payment is expected prior to your office visit

Please read the following carefully before signing.
I hereby authorize Nebraska Urgent Care Center LLC to release information acquired during the course of my examination and treatment to Centers for Medicare/Medicaid Services (CMS) and its agents, Medigap or any other third party carrier, as necessary, to secure payment of any benefits due. I hereby assign payment of said benefits to include Medicare and Medigap directly to Nebraska Urgent Care Center LLC for any medical procedures performed. I understand that I am responsible for all charges regardless of insurance status as well as any associated cost for collection should such action become necessary. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. A photocopy of this assignment shall be considered as valid as the original. I have read the above and fully understand there terms thereof.

Signature of patient or responsible party: _____

Patient Name:_____**Date of birth**:_____

HIPAA

Nebraska Urgent Care & Family Practice upholds the standards of the HIPAA laws. We respect the privacy of your personal medical records and we will do all we can to secure and protect that privacy. You may refuse to consent to the use or disclosure of your Personal Health Information, and conversely Nebraska Urgent Care & Family Practice Center provider(s) have the right to refuse to provide treatment as your PIH information is critical in making appropriate medical decision regarding your care while in our facility. A full copy of our HIPAA policy is posted at the front desk and a copy can be made for your records upon request. If you have any questions regarding this policy, please do not hesitate to ask a member of our staff.

Financial Agreement

Payment is due in full at the time of service including all applicable co0pays, co-insurance and deductibles as required by my insurance policy(s) unless other arrangements have been made in writing and signed by the patient and a staff member. I understand that my insurance policy is a contract between myself and my insurance company and also that it is my responsibility to determine whether this facility and its providers are in network and/or participating with my insurance company. I also agree to pay in full for services considered "non-covered" or for services that exceed "the usual and customary" as defined by my insurance carrier if I choose to have the services provided.

If my insurance policy does not pay in consideration of the services provided or if I do not have health or accidental insurance then I am considered to be a self paying patient and I am responsible for all charges applied to my account, including but not limited to; office visits, procedures, supplies, laboratory services, x-rays, medications, applicable taxes, finance charges and penalties. I acknowledge that there will be a $20.00 fee for any returned checks or for any non sufficient funds with credit/debit card payments. This charge does not include any other charges that may occur through your financial institution. I further agree to pay reasonable attorney fees and collection costs in the event that I default on my account(s).

I hereby authorize payment of medical benefits to Nebraska Urgent Care & Family Practice Center for services rendered to myself and/or dependants where it will be applied to my account(s). Nebraska Urgent Care & Family Practice will submit all applicable secondary insurance claims when payment from the primary carrier has been received. I also hereby authorize Nebraska Urgent Care & Family Practice to prepare any necessary reports and forms, to answer any requests from insurance carriers for medical information regarding my claim(s) to assist in the processing of payment.

I have read, fully understand, and agree to the above Consent to Treat, Release of Information, HIPAA, and Financial Agreement policies. My signature below indicates compliance with the above policies and information.

Signature of patient or responsible party_____**Date**: _____