Premier Urgent and Family Care Registration

Date:	
Patient Information	**Patient Phone Numbers**
First Name:	Home Phone:
Middle Name:	Cell Phone:
Last Name:	Work Phone:
Address:	**Emergency Phone Numbers**
Apt/Suite:	Name:
City:	Home Phone:
State: Zip:	Cell Phone:
Date of Birth:	Work Phone:
SSN:	
Gender: Male Female (Please Circle)	**Marital Status**
Employer:	Married Single Divorced Widowed (Please Circle)
School:	Spouse's Name:
Occupation:	Spouse's Employer:
Email (needed for patient portal):	

Health Insurance	**If the Patient is a Minor**
Subscribers Name:	Please enter the responsible party information. We do not bill absent parents. The adult presenting with the minor for care is the responsible party.
Relationship to patient:	
Subscriber Date of Birth:	
Subscriber SSN:	**Responsible Party Information**
Insurance Co:	Name:
Contract #:	Address:
Group #:	City:
Copay amount: $	State:
Additional Insurance:	Date of Birth:
Subscriber Name:	SSN:
Subscriber Date of Birth:	Home Phone:
Subscriber SSN:	Cell Phone:
Insurance Co:	Work Phone:

Pharmacy	**Note: This is where we will send ALL of your prescriptions unless you specify another pharmacy during your visit.**
Pharmacy Preference:	
Pharmacy Location:	
Do we have your permission to download your medication history?	

Medicare Authorization

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made to me or on my behalf to Premier Urgent and Family Care for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, My Medigap insurer, and their agents any information needed to determine these benefits for related services.

Insurance Assignment and Release

I certify that I have coverage with the above-named Insurance Company(ies) and assign directly to Premier Urgent and Family Care all insurance benefits. I authorize the use of my signature on all insurance submissions. Premier Urgent and Family Care may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purposes of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I hereby guarantee payment for services rendered by Premier Urgent and Family Care, LLC. I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all costs of collection, collection agency fees, and/or attorney's fees for services provided.

X

New Patient Consent to the Use and Disclosure of Health Information

For Treatment, Payment, or Healthcare Operations

I, _____understand that as part of my health care, Premier Urgent and Family Care originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among health professionals
- A source for applying medical information to my bill
- A means where third-party payers can verify the services billed were provided
- A tool for routine healthcare operations such as assessing quality and reviewing competency

I understand and have been provided a Notice of Information Practices providing a more complete description of information uses and disclosures. I understand I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions on the use or disclosure of my health information to carry out treatment, payment, or health care operations

I understand Premier Urgent and Family Care is not required to agree to the restrictions requested. I understand I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand by refusing to sign or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Premier Urgent and Family Care reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Premier Urgent and Family Care change their notice, they will send a copy of any revised notice to the address I've provided (whether US Mail or, if I agree, email).

I wish to allow the persons listed below to the use or disclosure of my health information:

_____

_____

Furthermore, I hereby consent for Premier Urgent and Family Care to:

(___) Leave a message on my home phone (___) Leave a message on my cell phone

(___) Leave a message with any person(s) listed above

I understand as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Signature_____Date_____

Premier Urgent and Family Care Medical History

Date:	Name:

What is the reason for your visit today?

Medication Allergies: Please List Medications and Reactions.

1	5
2	6
3	7
4	8

Food Allergies:

Environmental Allergies:

Medications: Please List All Medications, Amount, and Number of Times Taken Daily.

1	6
2	7
3	8
4	9
5	10

Past Medical History: Please check yes or no for each medical condition.

	Y or N			Y or N			Y or N			Y or N	
Abscess			Chicken Pox			Hepatitis			Reflux		
Angina			Chronic Pain			High Cholesterol			Scarlet Fever		
Anxiety/Depression			COPD			Hypertension			Seizures		
Arthritis			Cysts			Kidney Disease			STD's		
Asthma			Diabetes			Liver Disease			Stroke		
Bipolar			Emphysema			Migraines			Thyroid Problems		
Bleeding			Glaucoma			Mononucleosis			TIA		
Cancer			Heart Attack			MRSA			Tuberculosis		
Cellulitis			Heart Disease			Pneumonia			Ulcers		

Females:	Vaginal Discharge		Abn. PAP Smear		Abnormal Periods		Breast Lump		
Males:	Penile Discharge		Lump in Testicles		Erectile Dysfunction		Prostate Probs		

Other Medical Problems:

Past Surgical History: Please circle all surgeries you have had in the past.

Appendicitis	Gall Bladder	Orthopedic (Please List):
Breast Surgery	Hysterectomy	
Cardiac Bypass	Pacemaker	
Cardiac Stents	Prostate	
Caesarian Section	Tonsils and Adenoids	
D&C	Tubal Ligation	
Ear Tubes	Vasectomy	

Other Surgery:

Premier Urgent and Family Care Medical History

Date: **Name:**

Symptoms: Please circle any symptoms you are currently having or had in the past year.

Abdominal Pain	Excessive Thirst	Numbness	Swelling
Allergies	Excessive Urination	Pain in Joints	Urinary Problems
Anxiety	Fainting	Pain in Muscles	Visual Problems
Chest Pain	Fatigue	Palpitations	Weakness
Constipation	Fever / Chills	Shortness of Breath	Weight Gain
Cough	Headache	Sinus Problems	Weight Loss
Depression	Indigestion / Reflux	Skin Ulcers	Wheezing
Diarrhea	Memory Problems	Sleep disturbances	
Dizziness	Nausea / Vomiting	Sore Throat	

Other Symptoms:

Social History

Cigarettes Yes / No	Packs per Day:	Years Smoking:	Other Tobacco:
Alcohol Yes / No	Drinks per Day:	Years Drinking:	
Street Drugs Yes / No	Drug:	Frequency of use:	

Female Reproductive

Last menstrual period: _____/_____/_____ Number of Pregnancies: ____ Number of Living children: ____

Family History: This is only for your Mother, Father, Brother(s) and Sister(s).

Please circle who had the problem, their age of onset, and if living or deceased.

Heart Disease	Stroke	Diabetes	Cancer
Mom, Dad, Bro, Sis	Mom, Dad, Bro, Sis	Mom, Dad, Bro, Sis	Mom, Dad, Bro, Sis
Age	Age	Age	Age
Alive: Yes / No	Alive: Yes / No	Alive: Yes / No	Alive: Yes / No

Other Family Medical Problems:

Vaccines: Please provide the date of your last vaccine.

Tetanus Vaccine Date: | Flu Vaccine Date: | Hepatitis B Vaccine Date:

Comments / Additional Space:

Premier Urgent & Family Care
Dr. Bob Gilbert, DO

PATIENT PAYMENT POLICY

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

For your convenience, we have answered a variety of commonly asked financial policy questions below. If you need further information about any of these policies, please ask to speak with Billing Specialist or the Practice Manager.

How May I Pay?
We accept payment by cash, check, VISA, Mastercard and Discover.

Do I Need a Referral?
If your insurance requires you to have a primary care physician then you will most likely need a referral. Please call your insurance to obtain an authorization. Patients that need an insurance authorization and have not obtained one will have to reschedule their appointment.

What Is My Financial Responsibility For Services?
Your financial responsibility depends on a variety of factors, explained below.

- All Co-Pays and past balances must be paid prior to being seen.
- Premier Urgent and Family Care will file an insurance claim on your behalf.
- If the services you receive are not covered by the insurance plan: Payment will be due upon receipt of a statement.
- Balances not paid within 15 days of receiving a statement may be turned over to collections which in turn will incur a 35% collection fee.
- Worker's Compensation: If we have verified the claim with your carrier no payment is necessary at the time of the visit. If we are not able to verify your claim payment in full is requested at the time of the visit.
- Worker's Compensation (Out of Sate) Payment in full is requested at the time of the visit.
- Occupational Injury: Payment in full is requested at the time of the visit.
- No Insurance: Payment in full is requested at the time of the visit.

PATIENT SIGNATURE: _____ DATE: _____

PAYMENT COLLECTION CONSENT

You agree, in order for Premier Urgent and Family Care to service our account or to collect any amounts you may owe, our organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of our debt collection agency, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Our organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of our debt collection agency may also contact you by sending text messages or emails, using any e-mail address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and /or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that the Lender/Creditor, its ancillary providers, HIPAA business associates, vendors, and its debt collection agents may contact me/us as described above.

PATIENT SIGNATURE: _____ **DATE:** _____