Patient Registration

First Name | Middle | Last Name | Date of Birth

Address

City | State | Zip Code

Sex: ☐ M ☐ F

Social Security Number

Cell Phone | Home Phone

Emergency Contact | Relationship

Emergency Contact Phone

Preferred Pharmacy

Name and Location

Responsible Person ☐ **Self**

First Name | Last Name | M

Social Security Number | Date of Birth

Relationship to Patient

Address

City

State | Zip Code

Phone

How did you hear about our facility?

- ☐ Yelp
- ☐ Google
- ☐ Nellie Gail Urgent Care Website
- ☐ Facebook/Instagram
- ☐ SIRI
- ☐ Other (please specify):

_____

Race:

- ☐ White
- ☐ Black / African-American
- ☐ Asian
- ☐ American Indian / Alaskan Native
- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ Other:_____

Ethnicity:

- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino

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Preferred Language

Reason for visit | Duration of symptons

Work Related Injury? ☐ Yes ☐ No

Primary Care Physician | City/Zip Code | Phone/Fax

Medical History	
Past Medical History (Year of Onset) For example: Diabetes, Hypertension, Heart Disease, etc.	
Medications (Name/Dosage/Frequency) □ No medication	
Allergies □ No Medication Allergies	
Prior Surgeries and Hospitalizations (Year of Onset)	
Family History	Mother: Father:
Tobacco Use: ☐ Y ☐ N	Frequency:
Alcohol Use: ☐ Y ☐ N	Frequency:
Exercise: ☐ Y ☐ N	Frequency:
Recreational Drug Use (Confidential): ☐ Y ☐ N	Frequency:

Notice of Privacy Practices

I hereby acknowledge that I have read the practice's **Notice of Privacy Practices**. I further acknowledge that a copy the current notice will be posted in the reception area, and a copy of any amended Notice of Privacy Practices will be available at each appointment. I would like to receive a copy of any amended Notice of Privacy Practices by email.

E-mail:_____

Authorization and Consent

I verify that the information I have provided is correct and thereby request care from Nellie Gail Urgent Care or one of their affiliates for treatment of my medical condition, and/or for the routine or intensive care of me or my child. This care may include medical tests, exams, or other treatments that are needed for my condition, including minor surgical, emergency and/or laboratory procedures. In order to provide me or my child with the best care possible, I authorize Nellie Gail Urgent Care to use my medical history from other care providers and/or pharmacies, as well as to disclose Protected Health Information to any medical professionals that may contribute to mine or my child's treatment or care (HIPPA). I authorize Nellie Gail Urgent Care to e-fax my prescriptions to the preferred pharmacy I have indicated. I authorize the release of any information regarding me or my child for the purpose administering insurance benefits claims. I understand that if the provider has ordered additional laboratory testing of collected specimens, they will be sent to a local laboratory and they will forward my payer information to the laboratory but I will be responsible for the charges applied for these services.

Insurance and Payment Information

Nellie Gail Urgent Care receives payment for patient care from insurance companies and/or other third party programs. I hereby certify that, to the best of my knowledge, all statements contained here-on are true. I understand I am directly responsible for all charges incurred for medical service for myself and my dependants regardless of insurance coverage, excluding only authorized covered services. I agree to let my doctor(s) and/or the Nellie Gail Urgent Care to submit claims and required treatment information to my insurance company or other third party payment program for my care, and receive payments directly. I understand that I must pay all charges, co-payments, and deductibles that are not covered by my insurance company or third party payment program. Any overpayment will be refunded within 30 days of the insurance payment; however if there is an outstanding balance, the overpayment will be applied. Self-pay patients must pay, in full, at the time of service. There are no refunds for self-pay patients at the time of visits. I furthermore agree to pay legal interest, collection expenses, and attorney fees incurred to collect an amount I may owe. I also hereby authorize Nellie Gail Urgent Care to release information requested by the insurance company and/or its representative. I fully understand this agreement and consent will continue until cancelled by me in writing.

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Patient/ Guardian Signature Date Print Patient's Name

Authorization and Disclosure of Medical Information

Permission to Communicate with Your Primary Care Physician and/or Other Community Care Providers: I hereby authorize Nellie Gail Urgent Care release and disclose medical records from my visit to my primary care physician in order to ensure continuity of care. I understand that it is often necessary to communicate information to my primary care physician, other community care providers and to my insurance company. These communications may include information about my medical treatment and mental health or substance abuse treatment. This information is limited to that which is necessary to the determination of coverage and the coordination of my care. Many insurance companies require facilities to document whether or not patients will allow clinicians to communicate with primary care physicians and/or Health Insurance Companies.

Patient Partnership Plan

We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner-in-health," we ask you to help us in the following ways: **(1) Schedule Visits for Routine Physical Exams and Other Recommended Health Screenings**: I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears etc). These health screenings are test that can help detect life-threatening diseases and conditions. If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings. **(2) Keep Follow-Up Appointments and Reschedule Missed Appointment**: I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and do not reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible. **(3) Call the Office When I Do Not Hear the Results of Lab and Other Tests**: I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results. **(4) Inform My Doctor if I Decide *Not* to Follow His or Her Recommended Treatment Plan**: I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, at any time, to ask questions, report symptoms, or discuss any concern you may have. If you need more information about your health or condition, please ask.

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Patient/ Guardian Signature Date Print Patient's Name

By signing the agreements above, I certify that I am the patient or the legally authorized person to make healthcare decisions.