URGENT CARE OF OCONEE

Patient Information

Name: _____ **Date of Birth:** _____ **Gender:** □ Male □ Female

Address: _____
Street *City, State* *Zip*

Home Phone: (____)_____ **Work:** (____)_____ **Mobile:** (____) _____
*A confidential message may be left on your telephone answering machine, voice mail, or email.
**We do utilize texting to send reminders and follow up information.

Email address: _____ **Race**: □ Asian □ Black □ Hispanic □ White □ Other

Marital Status: □ Married □ Single

Emergency Contact – Name:_____

Relationship: _____ **Phone:** (_____)_____

Subscriber for Insurance: □ Self □ Spouse □ Parent **Name and Date of Birth**:_____

If patient is a minor,

Guarantor Name: _____ **Date of Birth:** _____

Gender: □ Male □ Female **Social Security #:** _____

Address:_____
Street *City, State* *Zip*

Home Phone: (____)_____ **Work:** (____) _____ **Mobile:** (_____)_____

Worker's Comp

Employer (Worker's Comp):_____Phone:_____

Employer Address:_____
Street *City, State* *Zip*

Visit Reason

□ **Illness** □ **Injury** □ **Physical** □ **Drug Screen** □ **Other**

Condition is related to: □ Work □ Auto □ Sports □ Other □ None

Today's Problem/Injury:_____

_____

Date of injury/onset of condition:_____ If Injury, Body Part:_____ Left or Right?

Primary Care Physician: _____

Preferred Pharmacy & Location:_____

URGENT CARE OF OCONEE

Medical History Questionnaire

ALLERGIES:(including latex, drug, food, seasonal)_____

MEDICATIONS: List all that you are currently taking, either prescription or non- prescription. Please specify dosage and length of time taking medication:

Medication	Dosage	How frequently?

Do you use tobacco products? □ Yes □ No **If yes, what kind and how many?** _____

Do you drink alcoholic beverages? □ Yes □ No **If yes, how many drinks per week?** _____

Are you pregnant? □ Yes □ No **If yes, how many weeks?**_____

Mother's Medical History: **Father's Medical History:**

_____ _____

Brother's Medical History: **Sister's Medical History:**

_____ _____

Patient Medical History: Have you ever been diagnosed as having any of the following conditions?

Yes	No		Yes	No	
		Cancer			Infectious Disease
		Chest Pain or Shortness of Breath			Hepatitis
		Heart Disease or Arrhythmia			Headaches Frequent/Severe
		High Blood Pressure			Hearing/Vision Difficulties
		Pacemaker			Numbness or Tingling
		Heart Attack			Dizziness
		Stroke or TIA			Weakness
		Congestive Heart Disease			HIV/AIDS
		Blood Clots			Mental Health
		Circulation Problems			
		Seizure Disorder or Epilepsy	**If yes, please explain:**		
		Thyroid Problems			
		Asthma or Emphysema			
		Chemical Dependency			
		Diabetes			
		Rheumatoid Arthritis			
		Other Arthritis Conditions			
		Fibromyalgia			

Surgery: List Type and Date_____

_____

_____

URGENT CARE OF OCONEE

Consent for Treatment

- I hereby consent to medical evaluations, testing, and/or treatment provided by the staff of Urgent Care of Oconee. I understand the benefits, risk, and possible side effects of receiving medications and vaccines and that it is my responsibility to provide any information relevant to health history, possible medication interactions and allergies.
- I understand that if the provider has ordered additional laboratory test that the collected specimens may be sent to a local laboratory for testing. Urgent Care of Oconee will forward my payer information to the laboratory, but I will be responsible for the charges incurred for these services and will receive a separate bill from the laboratory.
- I understand that there may be a portion of the cost of Durable Medical Equipment that is not covered by my insurance company and I will be responsible for the balance.
- I understand that Urgent Care of Oconee may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.
- I understand that Urgent Care of Oconee utilizes Physician Assistants.

Patient (or Guardian) Signature: _____ Date: _____

Patient's Name: _____ Date of Birth_____

HIPAA Patient Consent

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment, and follow-up care among multiple healthcare providers who may be involved in my treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal healthcare operations such as quality assessments or evaluation, and physician certifications.

I have been informed by UCO of the Notice of Privacy Practices containing a more complete description of uses and disclosures of my health information (available in office in print form or on the office website, **urgentcareofoconee.com**). I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that UCO has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address(s) below to obtain a current copy of the Notices of Privacy Practices. I understand that I may request in writing that UCO restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that the organization has acted relying on this consent.

Patient(Guardian)Signature: _____ Date: _____

Patient Name:_____ Date of Birth: _____

I give permission to Urgent Care of Oconee to verbally discuss the following with the individuals below. Please check:

- ☐ Scheduling and Appointment Information
- ☐ Medical Information: including my symptoms, diagnosis, medications, treatment plan.
- ☐ Lab Results
- ☐ Billing and Payment Information
- ☐ Other:_____

Name	Relationship	Contact Number
_____	_____	_____
_____	_____	_____

URGENT CARE OF OCONEE

Patient Name: _____ DOB:_____

Financial Policy

For Our Contracted Plans:

- We participate with **MOST i**nsurance plans, but please remember that insurance is a contract between the patient and the insurance company, and the patient is ultimately responsible for payment in full. It is your responsibility to know your own insurance benefits, including if we are a contracted provider, your covered benefits, and any exclusions in your policy. As a courtesy to our patients, we will verify your insurance coverage based on the information that is provided. Our verification is not a guarantee of benefits payable by your insurance. **The patient is responsible for any charges not covered by assignment of insurance benefits and all non-covered charges.**
- If your insurance requires a predetermined co-payment, we are contractually obligated to collect that co-payment at the time of service.
- If you are responsible for a co-insurance and have a remaining deductible, you will be asked to put your credit card on file to cover any portion determined to be your responsibility by your insurance company. You will receive a statement once this amount is determined. Your saved card will be charged **20 days** after the statement is sent unless payment is made otherwise.
- **We accept major card carriers (Visa, MasterCard, Discover, AMEX).** All credit card information will remain confidential and stored by a secure processor. Receipts are available upon request.
- **Failure to receive your statement does not relieve you from financial obligation. Please notify us of any address or phone number changes.**

If You Do Not Have Insurance: You will be asked to pay the $150 visit fee plus the cost of any additional services provided. This payment is due upon checkout. You will be notified of cost prior to services being provided.

Known Out of Network Insurances will not be accepted. We are happy to treat those patients at our self pay rate.

Worker's Comp/Auto Claims;

- If you are being seen due to a work related injury, we will first bill the employer's Workers Compensation policy. No payment is needed at the time of service, but if the claim is denied, the patient is ultimately responsible for these charges.
- If you were involved in an auto accident, you may choose to file a claim with your own auto insurance if you are covered for medical costs. We do not file 3rd party auto insurances.

Collections Policy: Any remaining balance older than **120 days** is sent to a 3rd party collections agency. **Please contact our office prior to 120 days to make payment arrangements if needed.** Once sent to collections, an additional **30%** will be added to the amount owed.

☐ I agree to the terms above and authorize Urgent Care of Oconee to charge the provided credit card for any outstanding balances **up to $150.00** on the date of service and up to 365 days. These charges are what remains after insurance reimbursement or denial. I guarantee and warrant that I am the legal cardholder for this credit card and that I am legally authorized to enter into this agreement with UCO.

I understand that this form is valid until I provide a 30 day written notice to cancel the authorization of this card. This card will also be linked to minor children.

☐ I agree to the terms above and DO NOT wish to provide a credit card on file.

_____ _____

Patient/ Guarantor Signature Date

WATKINSVILLE OFFICE
2061 Experiment Station Rd., Suite 505
Watkinsville, Ga 30677
706-310-0324 phone
706-310-0320 fax

MADISON OFFICE
1680 Eatonton Hwy., Suite A
Madison, GA 30650
706-343-4043 phone
706-438-1511 fax

ATHENS OFFICE
2375 W. Broad St., Suite G
Athens, GA 30606
706-567-6151 phone
706-434-8427 fax