Peachtree City Urgent Care

PATIENT REGISTRATION

Welcome to our office. In order to serve you properly, we will need the following information. **(Please Print)**
All information will be strictly confidential. Also, please provide the receptionist a picture id and your insurance card

Patient's Name	Sex M F	Birth Date ___/___/_____ Age_____	Marital Status Single [ ] Married [ ] Widowed [ ] Divorced [ ]
Residence address City State Zip		Home Phone: Cell Phone:	Patient's Social Security #
Person financially responsible for this account	Self Spouse Parent	Responsible Party's Birthdate ___/___/_____	Responsible Party's Social Security #
Responsible Party Drivers License # State: Number		Occupation	How Long at current Employer?
Name of employer Address		Business Phone	Occupation

Name of Spouse/Parent	Birth date	Social security #	Business phone
Reason for Visit:	Referred by: (include address and phone)		
Person to contact in case of emergency:	Relationship to patient	Phone	

Medicare Yes [ ] No [ ]	Medicare #	Medicaid Yes [ ] No [ ]	Medicaid #	Effective Date
Medicare Secondary insurance name Address			Policy #	Group #
Primary insurance company Address				Is insurance through your employer?
Subscriber Name	Subscriber birth date	Policy #		Group #
Secondary insurance name Address			Policy #	Group #

Medicare/Medicaid Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Peachtree City Urgent Care for any services furnished me by the physician and/or other medical providers. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information to determine these benefits payable for related services

_____ _____

Patient Signature Date

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Peachtree City Urgent Care for any services furnished me by the physician and/or medical providers. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims for medical benefits.

_____ _____

Patient, Parent or Guardian Signature (if child is under 18 years old) Date

MEDICAL HISTORY / MEDICATION SHEET

Patient Name: _____ **DOB:** _____ **Date of Visit:** _____

Please list all medications, vitamins, herbal supplements and any other over-the-counter medication you are taking with the strength and directions of each. (PLEASE LIST EVERY PILL YOU TAKE)

MEDICATIONS / VITAMINS	STRENGTH (Ex. 50 mg)	DIRECTIONS (Times a day)	MEDICATIONS / VITAMINS	STRENGTH (Ex. 50 mg)	DIRECTIONS (Times a day)

Please list all Medication Allergies: _____

Past Medical History: Please summarize your medical history. Indicate if you have had diabetes, hypertension, high cholesterol, cancer, thyroid, pulmonary, neurologic disease, kidney disease, gastroenterologic disease, etc. Note the approximate onset in months/years.

_____

_____

_____

_____

Family History: Please summarize illnesses that your family members (parents, brothers/sisters, etc.) have or have had. Include age at time of onset of illness and age at time of death (ex. Heart attack at 56 and died of heart failure at 60. He also had diabetes and high blood pressure. He was a heavy smoker)

Mother: _____

Father: _____

Brothers/Sisters: _____

Other: _____

_____

Social History:

Do you or have you ever smoked or used any other tobacco products? Yes No How much per day/week? _____

Do you consume alcohol? Yes No How much per day/week? _____

Past Surgical History: Please indicate type of surgery, date and why it was done (ex. Hysterectomy at 45 for fibroids)

_____

_____

How did you hear about our practice? _____

Primary Care Physician (address and phone number): _____

Release and Authorizations

Authorization for Treatment:
I present myself or child for whom I am guardian for diagnostic procedure(s) as may be ordered by the referring physician, his/her assistants, or his/her designee and authorize any emergency medical care. I am aware that practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the results of the examination by the center.

Authorization for Release of Information:

I authorize the center to disclose all or any parts of the patient's medical record to listed insurance companies, government agencies, the patient's employer or any agency conducting reviews concerning Worker's Compensation care and any review agency which conducts practice utilization review under an agreement with the patient's employer or other payment source. I also understand that I may revoke this authorization by providing written notice to this practice.

Medicare/Medicaid Patient's Certification:

I certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I request payment be made directly to the provider of services on my behalf and I authorize said provider to release any and all information necessary regarding the treatment and services provided as started below.

Assignment of Benefits:

I hereby authorize payment directly to the center by my insurance company(s). In the event an overpayment is made from more than one insurance company, I understand the overpayment will be sent to the appropriate payer.

Insurance:

The center will file your insurance as a service to you. If our office does not hear from your insurance company within 30 days, we request your help in contacting your insurance company to resolve the payment delay. The insurance plan is a contract between you and your insurance company. We must hold you responsible for any balance due.

Payment of Services:

I understand I am financially responsible for all charges and fees related to the services rendered to me by the center. I further understand that the payment in full is expected upon receipt of the first statement which may include co-payments, deductibles and any services not covered by insurance.

Notice of Privacy Practices:

I hereby acknowledge that I have received or have read a copy of the posted center's Notice of Privacy Practices.

Valuables:

I (we) understand that the center is not responsible for valuables and personal property brought to the facility.

Married or Dependent Patients:
I hereby consent to the release of any patient-related or financial information about me to my spouse (if married) or to my Parents (if a dependent child).

Patient/Guardian Name (please print)_____

Signature_____Date_____

Witness_____Date_____

Peachtree City Urgent Care

8 Eastbrook Bend, Suite B
Peachtree City, GA 30269
770-487-2273

(8) I understand that the physician, medical personnel and other assistants participating in the patient's care will rely upon the patient's documented medical history, as well as other information obtained from the patient, the family or others having knowledge regarding the patient, in determining whether to perform the Procedure(s) or the course of treatment for my/the patient's condition and in recommending the Procedure

_____ _____

Patient's Signature (Guardian if Minor) Date

_____ _____

Witness Date

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INFORMED CONSENT TO ROUTINE PROCEDURE/TREATMENTS

I understand that Physicians rendering services at Peachtree City Urgent Care are either owners, employees or independent professionals engaged in the private practice of medicine.

(1) I acknowledge and understand that, during the course of my/my child's care and treatment, it is likely that various types of routine diagnostic and treat procedures ("Procedures") may be utilized, which are considered necessary techniques for the ordinary care and treatment of my condition(s)

(2) While these types of Procedures are routinely performed in hospitals and doctors' offices without incident, there are certain risks associated with each of these Procedures.

(3) The physician or his/her associates or assistants are responsible for providing me with information about the Procedures and for answering all of my questions. It is not possible to enumerate each and every risk for every Procedure utilized in modern health care. However, physicians who practice medicine at Peachtree City Urgent Care have attempted to identify the most common Procedures, their associated risks and possible alternatives. If I have further questions or concerns regarding these Procedures, I agree to ask my/my child's physician to provide additional information.

(4) I further acknowledge and understand that my/my child's physician may ask me to provide a separate Informed Consent document to provide additional information.

The Procedures referenced herein may include, but are not limited to, the following:

(a) **Needle Sticks,** such as shots, injections or intravenous injections (IV's). The risks associated with these types of Procedures include, but are not limited to, nerve damage, causing tingling or burning, infection, swelling, bruising, infiltration (fluid leakage into surrounding tissue), skin sloughing, bleeding, clotting, allergic reactions or paralysis. Alternatives to Needle Sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective or refusal of treatment.

(b) **Physical test and treatments,** such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks, rehabilitation procedures, etc. which may be utilized in conjunction with diagnosis and treatment. The risks associated with these types of Procedures include, but are not limited to, reactions to the material(s) used, infection, bleeding, discomfort, muscular-skeletal or internal injuries, nerve damage, paralysis, bruising,

worsening of the condition and/or re-injury. Apart from using modified procedures and/or refusal of treatment, no practical alternatives exist.

(c) **Medications/drug therapy,** which may be utilized in the care and treatment of patients. The risks associated with these types of Procedures include, but are not limited to, food-Drug-herbal interactions, allergic reactions, adverse reactions, drug dependency and both long-term and short-term side effects, which vary from medication to medication. Apart from varying the medication prescribed and/or refusal of treatment, no practical alternative exist.

(d) **Repair of lacerations/cuts to tissues of the body.** The risks associated with this type of Procedure include, but are not limited to, fluid discharging through the suture line which would require additional treatment, scarring as part of the normal healing process, the wound may heal and stretch as time goes on causing some disfigurement, wound may heal with a thick scar which may be discolored and painful, edges of the wound may not be in perfect alignment and may overlap. Apart from refusal of treatment, no practical alternative exist.

(5) I consent to and authorize the persons participating in and responsible for my/my child's care to utilize the Procedures, such as those set forth above, as they may deem reasonably necessary or desirable in the exercise of their professional judgment, including those Procedures that may be unforeseen or not known to be needed at the time this consent is obtained. This consent shall also extend to the treatment of all conditions which may arise during the course of such Procedures including those conditions which may be unknown at the time this consent is obtained.

(6) **By signing this form, I acknowledge and understand that I have been informed in general terms of the following:**

(a) The nature and purpose of the Procedure(s);
(b) The material risks of the Procedure(s) and:
(c) The practical alternatives to such Procedure(s).

If I have further questions or concerns regarding these Procedures, I agree to ask my/my child's physician to provide additional information.

(7) I understand that the practice of medicine is not an exact science and that no guarantees or assurances have been made to me concerning the outcome and/or result of any Procedure(s).