

PATIENT DEMOGRAPHICS

Patient Information:

Social Security: _____

First Name: _____

Last Name: _____

Middle Name: _____

Preferred Name: _____

Check if information below is the same as check-in log.

Birthday: _____ Gender: Female Male

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Additional Information:

Primary Care Physician: _____

Office Phone: _____

Preferred Pharmacy: _____

Pharmacy Phone: _____

Pharmacy Address: _____

Emergency Contact Name: _____

Relation to Patient: _____

Phone: _____

Check if address is the same as patient info.

Address: _____

City: _____ State: _____ Zip: _____

Parent or Legal Guardian (if applicable)

First Name: _____

Last Name: _____

Relationship: _____

Primary Phone #: _____

Email: _____

Check if address is the same as patient info.

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Email: _____

Marital Status:

Child Divorced Married Single Widowed

Employer Name: _____

Employer Phone: _____

Employment Status: Disabled Full Time Part Time

Self Employed Retired Student Not Employed

Insurance Information (Guarantor/Main Insured)

First Name: _____

Last Name: _____

Phone: _____

SSN: _____ DOB: _____

Gender: Female Male Relationship: _____

Employer Name: _____

Do you have insurance with more than one health plan?

Yes No

Name of Secondary Insurance: _____

Check if address is the same as patient info.

Address: _____

City: _____ State: _____ Zip: _____

Printed Patient\Legal Guardian

Signature Patient\Legal Guardian

Date

CARENOW URGENT CARE
PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Patient Name (Printed): _____ Date of Birth: _____

Notice of Privacy Practice/clinics

_____ (Patient/Representative initials) I acknowledge that I have received the practice's/clinic's Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members.

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Communications about My Healthcare

I agree I may be contacted by the Provider or an agent of the Provider or an independent physician's office for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide the Practice/Clinic an email or text address at which I may be contacted, I consent to receiving instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained or, at any text number forwarded or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

Note: You may opt out of these communications at anytime. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: *This clinic uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.*

Patient/Parent/Guardian/Patient Representative Signature _____ **Date:** _____

Patient/Parent/Guardian/Patient Representative Name (Printed) _____

Patient Name (Printed): _____ **Date of Birth:** _____

Revised 6.11.2018