Graham Healthcare

Urgent Care

Patient Information

Today's Date:

PATIENT INFORMATION

First Name:	MI:	Last Name:	Suffix:	Social Sec #	Date of Birth:

Street Address:	City:	State:	Zip Code:	Cell Phone:

Your Email (Required):	Home Phone:	Work Phone:

Gender: ☐ Male ☐ Female	Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widow

Employer:	Employment Status:	Employer Phone No

Emergency Contact:	Contact Phone Number

Primary Care Physician (if none, please state none):	How did you hear about us?

If Referred by an other Facility or Physician, please give name: ______________________________

Please complete the following if you are a Legal Guardian, Guarantor, or responsible party to the patient.

Responsible Party:	Relation:	Resp Party DOB:

The above information is true to the best of my knowledge. I acknowledge, by signing below, I am the patient or parent/legal guardian of the patient, and I consent to treatment necessary for the care of the patient indicated on this form, and that I have also read and agree to the Patient Consent form.

Signature	***Date***

Insurance Information (ONLY IF YOUR INSURANCE CARD IS NOT PRESENT IN CLINIC)

Insurance Company's Name	Policy Holder's Soc Sec #	Policy Holder's DOB	**Policy Holder's Full Name**

Policy Holder's Address	**City**	**State**	**Zip**

Patient Relationship to Policy Holder	**Policy Holder's Employer**

Patient Medical History

Patient Name/DOB:___________________________________

Reason for visit today? ____

MAJOR ILLNESSES (List all past/current medical conditions)

- ❑ Hypertension____
- ❑ Diabetes____
- ❑ Cancer____
- ❑ Other____
- ❑ N/A

SURGERIES (Please list all major surgeries with estimated dates)

- ❑ No Surgeries to report

PLEASE LIST **MEDICATION ALLERGIES**: ____

____

FAMILY

	Hypertension	Diabetes	Cancer	Other (please Specify)
Mother	☐	☐	☐	
Father	☐	☐	☐	______________________
Brother	☐	☐	☐	______________________
Sister	☐	☐	☐	
Uncle	☐	☐	☐	______________________
Aunt	☐	☐	☐	
Grandmother	☐	☐	☐	______________________
Grandfather	☐	☐	☐	

SOCIAL HISTORY

Alcohol? ☐ No ☐ Yes If Yes, how much and how often? ______________________________________

Tobacco products?______________ ☐ No ☐ Yes If Yes, how much? ______________________________________

Recreational Drugs? ☐ No ☐ Yes If Yes, what substance? ____

ETHNICITY: ☐ Hispanic ☐ Not Hispanic ☐ Decline to specify

LANGUAGE: ☐ English ☐ Spanish ☐ Other (specify)______________________________

RACE

☐White ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Declined

MEDICATION LIST (please list dosage & reason for taking)

____

____

____

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Authorization for Disclosure of Protected Health Information

Patient Name:______________________________**Date**____________ **Full Address:**_
____
Phone Number:______________________________ **Maiden/Previous Name:**
____

Instructions: Please fill out each section of the form in its entirety. Failure to do so may delay processing of your request.

Release Information: ______________ *(to or from)*   Release Information: ______________ *(to or from)*

Graham Healthcare and Urgent Care **PHONE: 940-282-2512, FAX: 940-521-9139** **1005 State Hwy 16 South** **Graham, TX 76450**	**NAME:**
	FAX:
	PHONE:
	Address:
	City, State, Zip

Purpose of Release:

❑Continuing Medical Care	❑Work Comp	❑Other____________________
❑Insurance Claim	❑Disability Determination	____________________
❑Application for Insurance	❑ Personal	

Information to be Released:

❑ Entire Record
❑ Only Information related to (specify):
____
____

❑Only information of events
from________________to______________________________

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

❑All ❑None
❑Alcohol/Drug Abuse Treatment/Referral ❑HIV/ AIDs-Related Treatment

❑Sexually Transmitted Diseases ❑Mental Health
❑All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.

This authorization shall not expire until revoked by patient. I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage. I authorize the facility provider to (1) disclose medical information to the party identified in the "Release Information To" section. (ii) I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. (iii) I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected by federal privacy regulations. (iv) I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment or my eligibility for benefits.

______________________________ ______________
Signature *(required)* Date Signed

____
Printed Name of Parent or Guardian (if patient is a minor)

Graham Healthcare

Urgent Care

Patient Consent

To comply with the law and provide proper healthcare to you, we need the following consents.

Patient Name: (please print) ____

1). I consent to the treatment and care provided by Graham Healthcare Urgent Care and its associated physicians, nurses and other clinical providers. I am aware that the practice of medicine and other health care professions is not an exact science and that no guarantee has been or can be made regarding the results of the treatments.

2). I consent to the use and disclosure of any information about me including protected health information for the purposes of (i) obtaining payment for services rendered to me (ii) treatment, and (iii) health care operations consistent with the Graham Healthcare Urgent Care Notice of Privacy Practices.

3). I authorize payment of my insurance benefits to Graham Healthcare Urgent Care and/or the attending physician and their designee for services rendered. I understand that patient's insurance company may choose not to pay and I am financially responsible for the total charges for services rendered.

4.) I acknowledge that I received a copy of Graham Healthcare Urgent Care Notice of Privacy Practices and Graham Healthcare Urgent Care Payment Policy.

5.) I acknowledge patient registration information and medical history provided is true to best of my

The duration of this consent and authorizations continues until revoked in writing. By not signing, I am responsible for payment for services in full before the services are rendered.

Signature

____

Patient or (Patient Guardian's) Signature Date: __________

If applicable, Guardian Name: _ Date: __________

Graham Healthcare Urgent Care cares about you! Your satisfaction is important to us. While we wish to reduce paperwork, sometimes legal regulations and/or insurance requirements require that we ask for the same information multiple times. We share your frustration. Our goal is to make the patient experience as comfortable as possible. Thank you for choosing Graham Healthcare Urgent Care!

Graham Healthcare
Urgent Care

Payment Policy

Graham Healthcare Urgent Care strives to be your premier healthcare provider. Our payment policy helps us keep our doors open and to be fair to all of our patients. Graham Healthcare Urgent Care accepts cash payment and most insurance.

Insurance. Graham Healthcare Urgent Care will file your insurance for services provided at your visit. All managed care co- payment and/or deductible and coinsurance amounts are due at the time of the service.

Your insurance policy is a contract between you and your insurance company. It is important that you understand your coverage. We cannot guarantee payment of your claims. We will attempt to verify coverage, but that is not a guarantee of payment until your insurance has processed the claim. Per your insurance company guidelines, you may be responsible for any unpaid balance.

HMO/EPO/POS. If your plan requires a Primary Care Physician (PCP) assignment, you agree to obtain all referrals necessary for you to be seen. You can designate one of our Providers to be your PCP however the assignment must be effective the day of your appointments. All payments deemed by your insurance will be due at the time of service. No exceptions will be made.

Medicare. Graham Healthcare Urgent Care accepts assignment and will file insurance for our Medicare patients. However, calendar year deductible amounts (to the extent of the visit amount) are due at the time of the service. We will also file secondary insurance after payment from Medicare. If there is no secondary insurance, the patient will be billed for any remaining balance.

Cancel/No-Show. Patients must cancel or reschedule their appointment at least 24 business hours prior to their scheduled visit or they will be charged a fee of $25.00. This fee also applies to any patients that do not show up for their scheduled appointment. Excessive no shows and/or late cancellations could be grounds for termination from Graham Healthcare Urgent Care.

Returned Checks. Any returned check will result in a thirty dollar ($30.00) fee being assessed. After receiving a returned check, we will no longer accept check payments on any future visits not to exceed five years.

Collections. For all account balances in excess of 90 days past due a late fee of $50.00 will be added to the balance and the account will be turned over to our collection agency if payment is not received in 15 days. It is ultimately the patient's responsibility to make sure the doctor received payment for service rendered.

I have read this agreement and understand Graham Healthcare Urgent Care's policies. I agree to be responsible for any balance present on my account. If my insurance denies payment. I will assume full responsibility of the charges incurred for that visit and will pay in full.

If any patient is owed a refund, all claims must be processed and paid in full before overpayment is refunded.

Graham Healthcare Urgent Care is committed to making sure that every patients receives appropriate care that maximizes outcomes at the best value. These payment policies help ensure that we can continue to provide our services. We appreciate your cooperation! I have read this agreement and understand Graham Urgent Care/ Graham Healthcare policies

____________________________________ __________________

Sign **Date**

Graham Healthcare
Urgent Care

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14,2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this means to you: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential, except as is necessary, to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff .You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments .We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete, or modify any of these provision to better serve the needs of both the practice and patient.

You have the right to request restrictions in the use of your protected health information and request to change certain policies used within the office concerning your PHI; however, we are not obligated to alter internal policies to conform to your request.

I, ____ (patient name, printed), do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATIO N FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Patient signature:____ Date: __________________

Witness:____ Date:___________________

Prescription History Consent

I voluntarily consent to provide Graham HealthCare Urgent Care and its affiliated providers access to and use of my prescription medication history from other healthcare providers, insurance companies or third party pharmacy benefit payers for treatment purposes. This information will become part of your medical record.
I further acknowledge that Graham HealthCare Urgent Care and its affiliates may use health information exchange systems to electronically transmit, receive and/or access my prescription history.
I understand that this Prescription History Consent will be valid and remain in effect as long as I attend or receive services from Graham HealthCare Urgent Care, unless revoked by me in writing with such written notice provided to each practice site I attend and/or physician from which I receive services.
My signature below certifies that I have read and understood this form or the form has been read to me.

Date: ______________________

Print Name (Patient): ___________________________________DOB: ______________

Signature of Patient/Legally Authorized Representative:

____

Relationship to Patient (if Patient not signing):

____

For patients requiring translation or verbal reading of this document, the person reading or translating should document and sign below:
Reader/Translator Signature: ______________________________Date: ______________