MARTINEZ URGENT CARE, INC.

Patient Name: First ______________________ MI _____ Last ______________________
Address: ______________________ City: ______________ State: _____ Zip: _________
SSN: ______________________ Birth date: ______/______/______ Male ________ Female ________
Cell Phone: ( ) ______________________ Home Phone: ( ) ______________________
Email address: ______________________ Preferred Language: ______________ Race: ______________
Place of Employment: ______________________ Phone: ( ) ______________________
Who may we thank for referring you to us? ______________________
Emergency Contact: ______________________ Phone: ( ) ______________ Relationship: ______________
Reason for today's visit: ______________________
Are you ALLERGIC to any medication(s): ______________________
Current medication (please specify name, dosage & directions):

______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

Preferred Pharmacy (name & location) ______________________

HEALTH HISTORY

GENERAL	GASTROINTESTINAL	EYE, EAR, NOSE, THROAT	CARDIOVASULAR
□ Chills	□ Poor appetite	□ Blurred vision	□ Chest pain
□ Depression	□ Constipation	□ Difficulty swallowing	□ High blood pressure
□ Dizziness	□ Diarrhea	□ Double vision	□ Irregular heart beat
□ Fainting	□ Indigestion	□ Earache	□ Low blood pressure
□ Fever	□ Rectal bleeding	□ Loss of hearing	□ Poor circulation
□ Headache	□ Nausea	□ Nosebleeds	□ Rapid heart beat
□ Loss of sleep	□ Stomach pain	□ Persistent cough	□ Swelling of ankles
□ Nervousness	□ Vomiting	□ Sinus problems	□ Varicose veins
□ Sweats	□ Vomiting blood		

CONDITIONS (check any that you have or had in the past)

□ AIDS	□ Alcoholism	□ Anemia	□ Anorexia
□ Appendicitis	□ Arthritis	□ Asthma	□ Bleeding Disorders
□ Breast lump	□ Bronchitis	□ Cancer ______________	□ Cataracts
□ Chicken Pox	□ Diabetes	□ Emphysema	□ Glaucoma
□ Gout	□ Heart disease	□ Hepatitis	□ Hernia
□ Herpes	□ High Cholesterol	□ HIV Positive	□ Kidney disease
□ Liver disease	□ Measles	□ Migraine headaches	□ Multiple sclerosis
□ Mumps	□ Pacemaker	□ Pneumonia	□ Polio
□ Prostate Problem	□ Psychiatric care	□ Scarlet fever	□ Stroke
□ Suicide attempt	□ Thyroid problems	□ Tonsillitis	□ Tuberculosis
□ Ulcers	□ Vaginal infections	□ Venereal disease	

FAMILY HISTORY (CHECK IF YOUR BLOOD RELATIVES HAVE/HAD ANY OF THE FOLLOWING)

please specify: mother, father, etc....

□ Arthritis, Gout ______________	□ Asthma ______________	□ Cancer ______________
□ Diabetes ______________	□ Heart disease ______________	□ High blood pressure ______________
□ Kidney Disease ______________	□ Tuberculosis ______________	□ Other ______________

HOSPITALIZATIONS/SERIOUS ILLNESS/INJURIES

Year	Hospital	Outcome
________	______________________	______________________
________	______________________	______________________

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

______________________ ______________________
Signature Date

GUARANTOR information (A guarantor is the person responsible for paying the bills.)

First ______________________________ MI ____ Last ______________________________
Mailing Address: ______________________________ City: __________ State: _________ Zip:_________ ______
SSN: ______________________ Birth date: ____/____/____ Patients Relationship to Guarantor: ______________________
Home Phone: ( ) ______________________________ Cell: ( ) ______________________________

INSURANCE INFORMATION *If cash paying then skip to signature*

1. Primary Insurance Co. ______________________________
   ID #: ______________________________ Group #: ______________________
   Insured Person (owner of policy): ______________________________
   DOB: ______/______/______ SSN: ______________________________

2. Secondary Insurance Co. ______________________________
   ID #: ______________________________ Group #: ______________________
   Insured Person (owner of policy): ______________________________
   DOB: ______/______/______ SSN: ______________________________

FINANCIAL OBLIGATION FOR MARTINEZ URGENT CARE, INC.: I authorize payment of medical benefits to Martinez Urgent Care, Inc. for services rendered. I understand and agree that I am financially responsible for the payment of all charges that are my responsibility for services provided regardless of insurance coverage or other third party coverage unless waived by contractual agreements between Martinez Urgent Care, Inc. and my insurer or if prohibited by state, federal laws or regulations. If the charges, that are my responsibility, are not paid within thirty (30) days of receipt of the bill, I agree to pay any additional expenses incurred due to the delinquent account including the 35% collection agency cost if the account is placed for collections. All returned checks incur a $35 service charge to be paid by cash or credit card along with the balance of the patients account within 30 days of notification by Martinez Urgent Care, Inc. or its assigned agent. Failure to comply and meet financial responsibility may also result in a patient discharge from practice.

→ **Signature:** ______________________________ **Date:** ______________________

CONSENT FOR TREATMENT: I, the undersigned, a patient of Martinez Urgent Care, Inc. requests and authorize my attending physician to administer such treatment as is medically necessary. I voluntarily consent to said medical care, evaluation and treatment as well as any information release necessary to obtain such. This would include such services, care, diagnostic procedures, and/or medical treatments as the physician deems reasonable and necessary. These would include but not limited to, the performance of services involving pathology, radiology and immunizations. I authorize my medical records to be disclosed/released to my insurance carrier upon their request. I acknowledge that no guarantees have been made to me as to the results of treatment or examination.

→ **Signature:** ______________________________ **Date:** ______________________

PRIVACY NOTICE (HIPPA): by my signature below I acknowledge that the Health Insurance Portability and Accountability Act has been made available to me by Martinez Urgent Care, Inc. and a copy provided, upon request, for me at my discretion. I hereby authorize Martinez Urgent Care, Inc. to disclose information about myself (or another person for whom I have authority to sign) that is protected under federal law for the purposes of treatment, payment and healthcare questions.

I acknowledge that it is my responsibility as a patient or parent/guardian of Martinez Urgent Care, Inc. to notify the office in regards to any changes of the information provided verbally or contained within this patient information form to include insurance, mailing address, custody of minors and/or health information. Signature required by the patient, parent if minor child, guardian, or representative/caregiver if Medicare, for acknowledgement of the above Consent of Treatment, Financial Obligation and Privacy Notice.

→ **Signature:** ______________________________ **Date:** ______________________

MEDICATION HISTORY CONSENT: Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your "medication history". A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer.

An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose, information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record.

This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still important for us to take the time to discuss everything you are taking and for you to point out to us any errors in your medication history.

I give permission for Dr. Roger Brown, Martinez Urgent Care, Inc., to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.

→ **Signature:** ______________________________ **Date:** ______________________

PAYMENT POLICY

Thank you for choosing us as your healthcare provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have created a payment policy. Please read over it carefully, and ask us if you have any questions. At the end of reading over it fully please sign and date. A copy of this is made easily available to you upon request.

1. **Insurance.** We participate with most insurance plans, including Medicare. If you are not insured with a plan that we are currently in network with payment is expected in full at the time of service. If you are insured with an insurance plan that we are in network with but do not have an up to date insurance card payment is expected in full at the time of service. Once your current insurance information is given to us and we are able to submit a claim for reimbursement, we will promptly reimburse any amount overpaid by you.

2. **Co-payments and deductibles.** All co-payments must be paid PRIOR to being seen by the physician. Deductibles may be collected at the time of service or after we receive an explanation of benefits from your insurance carrier. This arrangement is part of your insurance contract with your insurance company. As a courtesy, in some circumstances we may bill you for this if payment is not able to be fulfilled on the date of service.

3. **Non covered services.** Please be aware that some and perhaps all of the services you receive may not be considered reasonable or necessary by Medicare or other insurance providers. On the chance of this happening or if the service is not an included benefit, you will be responsible for the service in full.

4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If we are not supplied with this information and your claim is denied the balance will be billed to you.

7. **Nonpayment.** If your account is over 90 days past due you will received a letter from us notifying you that if you do not pay your balance it will be turned over to collections. At this time you will need to contact our office and make a payment. If a payment plan is agreed you must supply us with card to keep on file. On the day of making the arrangements your card will be charged a minimum of $1 to verify that your card is active.

Our practice is committed to providing the best treatments to our patients. Our prices are representative of the usual and customary charge for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns

I have read and understand the payment policy and agree to abide by its guidelines:

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