PARAMOUNT URGENT CARE

Office use only: New, Established, Self-Pay, WC

Date: _____ **How Did You Hear About Us:**_____

Patient Information:

First Name:_____Middle Initial:_____Last Name:_____

Date of Birth:_____/_____/_____Age: _____ Sex: ☐M ☐F Marital Status: ☐Single ☐Married ☐Widowed ☐Other

Mailing Address:_____

APT/LOT:_____City:_____State:_____Zip Code: _

Home Phone:_____Cell:_____Work Phone: _____

Social Security Number:_____-_____-_____Email:_____

Is this Visit Related to:

Employer Testing: ☐YES ☐NO If yes, Employer Name:_____Ph: _____

Work Related Injury (workers compensation): ☐YES ☐NO If yes: Employer:_____Ph:_____

Motor Vehicle Accident: ☐ YES- **PLEASE SEE RECEPTIONIST NOW** ☐NO

Who Would You Like Us to Call in Case of an Emergency?

1)Emergency Contact Name:_____Relationship:_____

Home Phone Number:_____ Cell Phone:_____

2)Emergency Contact Name:_____Relationship:_____

Home Phone Number:_____ Cell Phone:_____

I give Paramount Urgent Care, Inc. permission to speak with the above-named person about my medical condition.

Please INITIAL:_____

If Patient is under 18 years of age, Enter Parent or Guardian Information:

First Name:_____Middle Initial:_____Last Name: _____

Date of Birth:_____/_____/_____ SS#:_____-_____-_____ Relationship to Patient:_____

Cell Phone:_____Email:_____

Policy Holder Insurance Information- ***if not the patient*****: (PLEASE PRESENT INSURANCE CARDS AND I.D TO RECEPTIONIST)**

Insurance Company Name:_____

Primary Policy Holder Name: _____

Date of Birth: _____

Social Security Num:_____

Patient Relationship to Policy Holder:_____

Secondary Insurance Name:_____

Primary Policy Holder Name: _____

Date of Birth: _____

Social Security Num:_____

Patient Relationship to Policy Holder: _____

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Patient: _____ **Reason for Visit:** _____

Pharmacy: _____ **Lab:** Labcorp Quest

B/P: _____ **Pulse:** ____ **Resp:** _____ **Temp:** _____ **Weight:** _____ **Height:** _____ **O2:** _____

PMH: _____
_____
_____
_____
_____

Rx: _____
_____
_____
_____
_____

Surg Hx: _____
_____
_____
_____
_____

Allergies: _____
_____
_____
_____
_____

Have you traveled outside of the U.S. within the past 30 days?

◌ **Yes** ◌ **No**

Have you had a flu shot this season?

◌ **Yes** ◌ **No**

(65 & Older) Have you had a pneumonia shot?

◌ **Yes** ◌ **No**

Soc Hx:

Smoke : ◌ **Yes** ◌ **No**

Drink: ◌ **Yes** ◌ **No**

Drugs: ◌ **Yes** ◌ **No**

Vision:

Left: 20/_____

Right: 20/_____

(Female Patients)

LMP: _____

Pregnant:

◌ **Yes** ____ **wks** ◌ **No**

NOTES :

_____
_____
_____
_____
_____
_____

Patient Name:_____ **Date of Birth:**_____

Primary Care Doctor:_____ **Ph:**_____

Reason for Visit (Please provide at least one symptom):_____

Personal Habits:

Smoke tobacco? ☐Yes ☐No If Yes, How Many Per Day?_____ ☐Former Smoker?____yrs

Drink Alcohol? ☐Yes ☐No If Yes, How Many Drinks?_____ ☐DAY ☐WK ☐MTH

Drug Use? ☐Yes ☐No If Yes, which drug(s)?_____

Employment Status: ☐Full Time ☐ Part Time ☐Unemployed ☐Disabled ☐Student ☐Retired

Medical History: Check all that apply: (SF= Self, M= Mother, F= Father): ☐ No Past Medical History ☐ No Family Medical History

	SF	M	F		SF	M	F		SF	M	F		SF	M	F
A-Fib	☐	☐	☐	Congestive Heart Failure	☐	☐	☐	Heart Attack	☐	☐	☐	Osteoarthritis	☐	☐	☐
Anemia	☐	☐	☐	Diabetes Type I	☐	☐	☐	Hernia	☐	☐	☐	Stroke	☐	☐	☐
Anxiety	☐	☐	☐	Diabetes Type II	☐	☐	☐	HIV or AIDS	☐	☐	☐	Thyroid Disease	☐	☐	☐
Asthma	☐	☐	☐	Diverticulitis	☐	☐	☐	High Cholesterol	☐	☐	☐	Tuberculosis	☐	☐	☐
Blood Clots	☐	☐	☐	Epilepsy/ Seizures	☐	☐	☐	High Blood Pressure	☐	☐	☐	Cancer(specify)_____	☐	☐	☐
Chronic Bronchitis	☐	☐	☐	Fibromyalgia	☐	☐	☐	Kidney Disease	☐	☐	☐	Dialysis Port Location:_____	☐		
Coronary Artery Disease	☐	☐	☐	Gout	☐	☐	☐	Liver Disease	☐	☐	☐	Other:_____	☐	☐	☐
COPD	☐	☐	☐	GERD	☐	☐	☐	Migraines	☐	☐	☐	Other:	☐	☐	☐

Medications: ☐**No Medications Taken** ☐ **See List (give list to receptionist)**

Name	Dose	Reason for Taking

Past Surgical History (List Any Major Surgical History): ☐**No Past Surgical History**

_____

_____

Allergies: ☐ **No Known Allergies**

□ Acetaminophen/Tylenol	□ Iodine	□ Penicillin's/ Amoxicillin
□ Aspirin	□ IVP Dye/Contrast	□ Sulfa Drugs
□ Codeine	□ Latex	□ Toradol/Ketorolac
□ Erythromycin	□ Lidocaine/ other anesthetics	□ Adhesive Products
□ Ibuprofen/Advil	□ Morphine	□ Other:_____

Race- check the box which best describes you: (*please choose one)*		**Ethnicity: (*please choose one)***
☐White/Caucasian	☐American Indian or Alaska Native	☐Non-Hispanic
☐Native Hawaiian or Other Pacific Islander	☐Other Race	☐Hispanic
☐Black/African American	☐I prefer not to answer	☐I prefer not to answer
Please indicate your preferred spoken language: ☐**ENGLISH** ☐ **SPANISH** ☐**OTHER:** _____		

Patient Responsibility Disclosure Statement

PLEASE READ AND SIGN BELOW

Your signature below forms a binding agreement between Paramount Urgent Care (the provider of medical services) and the Patient who is receiving medical services, or the Responsible Party for minor patients (those patients under 18 years of age). The Responsible Party is the individual who is financially responsible for payment of medical bills.

HIPAA: If you would like a written copy of the HIPAA laws, please notify our staff. If not, signing below acknowledges that you have waived the written copy.

Co- Pays: All co-payments and past due balances are due at the time of service. If your insurance requires any additional co-payments you will be responsible for payment and will be billed for it. As we are an Urgent Care facility, the urgent care co-payment will apply. If no urgent care co-payment is listed on your card; we will charge you the specialist co-payment.

****Sorry, we are unable to accept checks for first time patients****

HMO Plans: If my Insurance plan is an HMO, I understand that an authorization from my primary care physician may be required for my insurance company to cover services provided by Paramount Urgent Care. I agree to contact my PCP to obtain authorization for my visit. If an authorization is not secured, or my plan declines coverage, I will assume responsibility for the charges incurred.

Out of Network Plans: I acknowledge that it is my responsibility to verify whether Paramount Urgent Care is in-network with my insurance plan. I agree to pay any balance which results from out-of-network charges.

Authorization to pay benefits to the physician: All insurance checks that may go directly to the patient MUST be signed over to Paramount Urgent Care for payment for services rendered. Failure to do this will result in the patient receiving a bill for services. I hereby authorize payment for medical services provided directly to Paramount Urgent Care.

Patient Refunds: All patient refunds will be kept as a credit on the patient's account toward their next visit unless a refund request is initiated by the patient. The following criteria must be met prior to issuing a patient refund: There are no outstanding insurance claims or no outstanding patient balances on the account.

Returned Check Policy: If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $35.00 Service Charge. If no payment is received within 90 days, the patient's account will go to a collections agency & the patient will be discharged from the practice. **Collections**: If your account is turned over to collections, for any reason, a $25 processing fee will be added to your existing balance due. Please make sure that if a claim becomes your responsibility that you pay the balance according to payment terms of Net 30 days. Our office will send out multiple statements prior to turning your account over to our collection agency. No prior notification will be sent to you regarding further action.

Durable Medical Equipment: As we are an URGENT CARE facility, we have urgent care contracts with most major health insurance companies. In abiding with our contract guidelines, we CANNOT bill insurance companies for DME (Durable Medical Equipment) such as crutches, slings, braces, and extremity immobilizers. We carry these products as a convenience, and they are available to our patients as an out-of-pocket expense. By signing, you acknowledge your understanding that any DME supplies cannot and will not be submitted to your insurance company by you or Paramount Urgent Care for reimbursement.

Visit Follow-Up Communication

TEXT MESSAGE AND INFORMED CONSENT: In order to enhance patient's care and experience, Paramount Urgent Care may contact you after your visit in order to request feedback of your experience by phone call, SMS text message, e-mail, voice mail, or mobile application, some of which may be via automated means. By signing below, you understand and agree to be contacted in this manner with regards to your experience related to this visit, and any future visits.
In the future, you may opt-out of receiving text messages by notifying us in writing (including responding via text message). Standard telephone minute and text charges may apply if we contact you.

Consent to Treat/ Receipt of Documents

CONSENT TO TREAT: The above information is true to the best of my knowledge. Insurance policy limitations may not cover today's visit. I understand and agree that I am responsible for paying any non-covered charges, deductibles, and co-payments. I authorize Paramount Urgent Care or insurance company to release any information required to process my claims or to release any medical records to additional Providers as required. Additionally, I have read and understand my Health Information Patient Privacy Rights.
RECEIPT OF DOCUMENTS: BY SIGNING BELOW I ALSO ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE OFFICE FINANCIAL POLICY AND THE HIPAA PRIVACY STATEMENT.

→ **Patient Name (PRINT)**: _____ **Date of Birth:** / /

→ **Signature:** _____ **Date**: / /