TOTAL POINT URGENT CARE

SECTION 1

Have you traveled to China or any areas with confirmed cases of the Coronavirus within the last 14 days?

Yes _____ No_____

Have you been in close contact with a person known to have Coronavirus or that has traveled to any areas with confirmed cases of the Coronavirus within the last 14 days?

Yes _____ No_____

SECTION 2

Do you have any of the following symptoms:

Fever > 100.4 °F (38°C)
Cough
Shortness of Breath

Yes _____ No_____

TOTAL POINT URGENT CARE

Staff Use Only: PID# _____ **Scanned by (initials):** _____

Patient Arrival Time: _____ **AM / PM**

Date ____/____/____

DEMOGRAPHICS

Need help with forms? Yes _____ No _____ | **Preferred Language:** English _____ Spanish _____ Other _____

Name: (Last) _____ (First) _____ (MI) _____ (Suffix) _____

Minor: Yes __ No __	**Birth Date:**	**Social Security Number:**	**Gender:** Male__ Female __

Street Address:	**Apt #**	**City:**

State:	**Zip:**	**Country:**	**Home Phone:**	**Cell Phone:**

Best Form of Contact: Home Phone ____ Cell Phone ____ | **May we leave a detailed massage?** Yes ____ No ____

Email:	**Marital Status:**

Primary Care Physician: (Name)	**Phone:**	**City:**
Preferred Pharmacy: (Name)	**Location:**	**Phone:**
Emergency Contact: (Name)	**Phone:**	**Relationship:**

Name of Guarantor: | **Guarantor Date of Birth:** _____/_____/_____

Street Address:	**Apt #:**	**City:**

State:	**Zip:**	**Country:**	**Home Phone:**	**Cell Phone:**

How did you hear about our Urgent Care Clinic? Drive by ____ Internet ____ Mailer ____ Radio ____ Family/Friend ____ Other _____

Race: American Indian/Alaskan Native ___ Asian ___Black or African American ___Native Hawaiian/Pacific Islander ___ White ____

Ethnicity: Hispanic or Latino ____ Not Hispanic or Latino ____

PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS (TO A DOCTOR OR FAMILY MEMBER)

____ **Patient Authorization to Release Medical Records:** I authorize the custodian of records or other person/entity (specifically describe) to disclose/release the following information* (check all applicable) All Records ____ Billing Records ____ Other _____

Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse or STDs, you are hereby authorizing disclosure of this information.

To (Name): _____ **Relationship:** _____

Signature of Patient (or Guardian): _____ **Date:** _____/_____/_____

___ **Insured** ___ **Self-Pay (FFS)**	**Primary Ins Subscriber Name:** _____ **Name of Primary Insurance:** _____ **Date of Birth:** _____/_____/_____ **Relationship:**	**Secondary Ins Subscriber Name:** _____ **Name of Primary Insurance:** _____ **Date of Birth:** _____/_____/_____ **Relationship:**
___ **Auto**	**Name of Ins:** **Phone:** **Accident/Claim #:**	
___ **Work Related**	**Company Name:** _____ **DER (Company Representative):** _____ **Company Phone Number:** **Email:**	

TOTAL POINT URGENT CARE

PATIENT ACKNOWLEDGMENT & CONSENT, TREATMENT COVERAGE & COMMUNICATION

PLEASE INITIAL AND SIGN TO SELECT YOUR CURRENT METHOD OF COVERAGE.

_____SELF-PAY (FFS) PATIENT VISIT

By signing below, I acknowledge that I have been informed of my responsibility to pay for the professional services or supplies provided to me today by Total Point Urgent Care. I understand that these costs must be paid prior to the provision of such services through its authorized representatives . I also acknowledge and fully understand that the service(s) requested today will not be billed to any insurance carrier(s) at my request. I also understand that today's service(s) will be provided at a discounted rate and waive any right that I may have to require Total Point Urgent Care to attempt to bill any insurance carrier for these services. I further acknowledge that if I choose to submit an itemized receipt to any insurance carrier(s) for evaluation of partial or full reimbursement for these services that Total Point Urgent Care is exempt from any subsequent dispute regarding reimbursement but retains the option to submit these services for payment under the non-discounted insurance rates and guidelines upon mutual agreement by both parties when appropriate insurance information has been provided to Total Point Urgent Care.

_____ HEALTH INSURED PATIENT VISIT

I request that payment of authorized insurance benefits, including Medicare, be made on my behalf for any professional services or supplies provided to me by Total Point Urgent Care. I acknowledge that I have provided my insurance information today and authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related professional services or supplies by Total Point Urgent Care, my insurance company or other entity upon request to secure payment of my benefits. I understand that I am financially responsible to Total Point Urgent Care for any charges not covered by health care benefits. It is my responsibility to notify "TPUC " of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I understand that I am responsible for the entire bill including any unpaid balance of the professional services or supplies as determined by Total Point Urgent Care Clinic and/or my health care insurer should the submitted claim or any part of the claim be denied for payment or apply to my co-pay, deductible or coverage limitations.

PLEASE INITIAL AND SIGN TO ACKNOWLEDGE AND CONSENT FOR MEDICAL TREATMENT, NOTICE OF PRIVACY PRACTICES, AND PAYMENT POLICY

_____ CONSENT TO MEDICAL TREATMENT

I voluntarily present for treatment and consent to my Total Point Urgent Care Clinic provider to provide my care. Such care may include, but is not limited to, diagnostic procedures, x-rays, blood draws, laboratory tests, medication administration, and other procedures considered advisable in my diagnosis, treatment and course of care. I acknowledge that my treatment is intended to address specific, episodic illnesses or injuries and is not intended as a substitute for a primary care physician or other specialized physician and that no guarantee can be made or has been made as to the results of treatments or examinations at Total Point Urgent Care

_____ NOTICE OF PRIVACY PRACTICES

This consent includes testing for communicable blood-borne diseases, including, without limitation of, Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Virus (AIDS), and Hepatitis if a physician orders such test(s) for diagnostic or treatment purposes. I understand that in the case of an accidental exposure to blood or other body fluids, state law allows the Emergency Room to test a patient that has exposed healthcare worker to HIV without obtaining the person's consent. I understand the potential side effects and complications of this testing are generally minor and are comparable to the routine collections of blood specimens, including discomfort from the needle stick and/or slight burning, bleeding, or soreness at the puncture site. The results of this test will become part of my confidential medical record.

_____ OFFICE POLICY ON PAYMENT

It is our policy to require all co-payments to be made at the time of service. In the event any balance is not paid as agreed, the undersigned agrees to pay all costs charged by the Collection Company and reasonable attorney fee. I understand that by signing this form I am accepting full financial responsibility as explained above for all professional services and supplies received. I understand this original authorization will be kept on file by "TPUC" and does not expire unless written notice is provided by me.

Name of person signing below (print):

_____

Signature of Patient or Guardian:

_____

Today's (visit) Date: _____/_____/_____

Relationship to Insured:

Self ___ Spouse ___ Dependent ___ Other ___

Relationship to Patient:

Self ___Spouse ___Dependent ___ Other ___

TOTAL POINT URGENT CARE

HIPAA ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

TOTAL POINT URGENT CARE

I understand, that under the Health Insurance Portability & Accountability Act of 1996 ('HIPAA'), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may beinvolved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I can contact this organization at any time at the address above to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature of Authorized Patient: _____

Print Patient Name: _____

Date Signed by Patient:_____/_____/_____

Relationship to Patient: Self ___ Spouse ___ Dependent ___ Other ___

FOR OFFICE USE ONLY IF PATIENT DOES NOT SIGN ABOVE

I attempted to obtain the patients signature in acknowledgement on this **Notice of Privacy Practices** Acknowledgement but was unable to do so as documented below.

- Individual refused to sign
- Communication barriers prohibited obtaining theacknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify): _____

Signature of Administrative Assistant: _____

Date Signed by Administrative Assistant: _____/_____/_____

TOTAL POINT URGENT CARE

Please tell us what you would like to be seen for today

_____

When did it start bothering you? _____/_____/_____ (date of onset)

We re you injured? Yes ___ No ___ **At Work** ___ **Auto Accident** ___ **At Home** ___ **Other:** _____

Next, review the symptoms below and mark any symptoms **related to your visit today**. If an area is normal, or not related to today's visit, do not mark.

GENERAL	___ Pain: _____(Location) Fever ___ Chills ___ Fatigue ___ Weaknes ___ Unusual Weight Changes ___
EYES	Something in the eye ___ Redness ___
Vision Problems (blurry, loss of sight)	Dryness ___ Excessive tearing ___ Scratchy sensation ___ Wear glasses / contacts ___
EARS	Ringing in ears ___ Hearing Loss ___
NOSE	Nosebleed ___ Sinus Pain ____ Runny Nose ____
MOUTH / THROAT	Growth in mouth ___ Hoarseness ___ White spots ___ Tongue pain ___ Soreness ___ Toothache ___ Trouble swallowing ___ Swelling ___
HEART & CIRCULATION	Chest Pain ___ Tightness ___ Pressure ___ Faintness ___ Lightheaded ___ Fast Heartbeat ___ Slow heartbeat ___ Palpitations ___
LUNGS	Shortness of Breath ___ Cough ___ Wheezing ___ Snoring ___ Apnea ___
STOMACH / INTESTINES	Nausea ___ Vomiting ___ Rectal Bleeding ___ Indigestion ___ Food intolerance ___ Cramping ___Diarrhea ___ Constipation ___ Bloating ___ Gas ___
GENITAL	Sores ___ Discharge ___ Abnormal Period / Last Perod: _____ Swelling ___ Pain ___ Bleeding ___
URINARY	Frequent urinating ___ Losing control of urine / wetting self ___ Painful urination ___ Blood in urine (discolored urine) ___
MUSCLES / JOINTS & BONES	Joint stiffness ___ Pain _____ (location) Muscle pain ___ Cramps _____ (location)
SKIN	Wound/ sore _____ (location) Rash _____ (location) Dryness ___ Itchiness ___
BLOOD / LYMPH	Easy bruising ___ Easy bleeding ___
ALLERGIES	Seasonal allergies ___ Hives ___ Welts ___ Other: _____
NERVOUS SYSTEM	Recent head injury ___ Dizziness/ Vertigo ___ Speech problems ___ Memory loss ___ Fainting ___ Blacking out ___ Seizures ___ Sudden Paralysis ___ Headaches ___ Poor Balance ___ Tingling ___ Loss of Coordination ___ Numbness ___ Weakness ___
PSYCHOLOGICAL	Depression ___ Loss of interest ___ Nervousness ___ Anxiety ___
HORMONES	Heat intolerance ___ Cold intolerance ___ Night Sweats ___ Hunger ___ Increased Thirst ___

Patient Name: _____

Patient Signature: _____

Patient Date of Birth: _____

Primary Care Provider: _____

Today's Date: _____/_____/_____ (Date of Visit)

_____

FOR CLINIC USE ONLY

Clinic Use Only: Provider Name: _____

Clinic Use Only: Provider Signature: _____

Clinic Use Only: Date: _____/_____/_____

BP: _____ LMP: _____TEMP: _____ PAIN LEVEL: _____

O2: _____ WEIGHT: _____ HR: _____

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ALLERGIES

None ___ I am allergic to latex ___ I am allergic to band-aids ___

___ Yes, Medication Allergies: _____

___Yes, other Allergies: _____

CURRENT MEDICATIONS (include birth control, vitamins, supplements, herbals, over the counter & prescriptions)

Medication Name & Dose: _____

_____

_____

Preferred Pharmacy: _____

PAST MEDICAL HISTORY (ex. Cancer, diabetes, high blood pressure, depression, surgery)

Medical Conditions: _____ None ___

Surgeries: _____ None ___

Major Accidents: _____ None ___

Other: _____

FAMILY HISTORY Please list any diseases that your immediate family have. List relative and disease.

Relative: _____ Disease(s): _____

Relative: _____ Disease(s): _____

Relative: _____ Disease(s): _____

None ___ Adopted ___

IS THERE A CHANCE YOU ARE PREGNANT? Yes ___ No ___ **DO YOU HAVE A PACEMAKER?** Yes ___ No ___

HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?

Feeling down, depressed, or hopeless?	Yes ___ No ___
Feeling tired or having little energy?	Yes ___ No ___
Have you been told that you snore loudly?	Yes ___ No ___
Do you experience any of the following:	**Dizziness/ Motion Sickness:** Yes ___ No ___ **Anxiety:** Yes ___ No ___
Have you been diagnosed with ADD/ADHD?	Yes ___ No ___
Do you feel tingling sensation pain or burning in your hand/ feet?	Yes ___ No ___
Do you smoke or use tobacco?	Yes ___ No ___
Do you consume alcohol?	Yes ___ No ___

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

TOTAL POINT URGENT CARE

FINANCIAL WORKSHEET

Form of Payment:

Cash _____ Credit Card _____ None _____

Total Amount Collected: $ _____

Attach Copy of Check / Credit Card Receipt / Cash Receipt and photocopy for chart below:

Administrative Assistant Name (Print): _____