# PALMERS URGENT CARE AND Diagnostics

**5409 N. ST. RD. 7 FL, 33319 PH: 954-526-9477**

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**REASON FOR VISIT**: Sick visit( )_ Minor injury( ) Wellness/Annual checkup ( ) DOT physical ( )_
School Physical _( )_ Employment Physical_( )_ Immigration Physical_( )_ Shots/Immunization____
Other ____________________________________________________________________________

**PATIENT INFORMATION**:

Status: ( ) Minor ( ) Single ( ) Married ( ) Divorced ( ) Widowed

Last Name: __________________________ First: _________________________ M.I.________ Sex: M F
Social Security #___________________________ Date of Birth: ________________ Age: ___________
Address: ___________________________ City: ________ State:_______Zip:____________

Home # __________________________Cell #_________________

Name of Employer:_____________________________Phone:_______________________________

**INSURANCE POLICY HOLDER (If different from Patient):**

Last Name: __________________________ First: _________________________ M.I.__________Sex: M F
Social Security #__________________Date of Birth: ___________Driver's License #_______________
Address:_______________________________________Home#:________________Cell#:______________

Name of Employer: __________________________________Phone:_______________________________

**SPOUSE INFORMATION** (If different from above):

Last Name: _________________________ First: ________________________M.I.___________ Sex: M F

Address__________________________________Home#____________________Cell#:________________

**GENERAL INFORMATION**:

Family Physician Name: __________________________________ Phone: __________________

Nearest Relative (not living with you) ______________________ Phone: ___________________

In case of Emergency Notify: _________________Phone:________________ Relationship: ___________

**INSURANCE INFORMATION:**
Who referred you to our office? (Doctor/Friend/Phonebook)___________________ Phone: ___________
Primary Insurance Plan: _________________________Policy Holder's Name: ________________________
ID#:_____________________________Group#______________________Phone#:____________________
Secondary Insurance Plan: _____________________Policy Holder's Name:_________________________
ID#:_____________________________Group#:______________________Phone#:___________________
**HIPAA INFORMATION**: Instructions for the office when returning phone calls or reminding you about appointments. I authorized the office to contact me at: [ ] Home [ ] Work [ ] Cell and May leave messages at: [ ] Home [ ] Work [ ] Cell I authorize the office to leave detailed messages about appointments/phone calls: Y__N__
**Names of specific individuals you prefer us to leave message with: _____________________________________**

Patient (or Parent/Guardian) Signature_______________________________ Date: _____________

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# PATIENT PERSONAL HEALTH INFORMATION CONSENT FORM

The Department of Health and Human Services has established a “Privacy Rule” to help ensure that personal health care is protected for privacy. The privacy rule was also created in order to provide a standard for certain health care providers to obtain their patient’s consent for uses and disclosures of health information about the patient to carry out treatment, payment, or healthcare operations. As our patient we want to know that we respect the privacy of your personal records and we will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or healthcare operations, in order to provide health care that is in your best interest. We also want to know that we support your full access to your personal medical records. We may have indirect treatment relationship with you (such as laboratories that may only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but must be in writing. Under this law we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your **PHI**. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak to our **HIPPA** compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name__________________________Signature________________________________Date: _______________________

# COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the “Privacy Rule. “We strive to achieve the very highest standard of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate uses of PHI in accordance with the government rules, laws and regulations. We want to ensure that our practice never contribute in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

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**FINANCIAL RESPONSIBILITY AGREEMENT**

We are happy that you selected **Palmers Urgent Care Center and Diagnostics, Inc.** for your healthcare needs and look forward to working with you. To help you understand your financial responsibilities in relation to your medical care, we would like to briefly outline our financial policies.

Patients are expected to provide identification and if insured, a current insurance card(s) at time of service. Patients are financially responsible for all services provided and are expected to pay for services at time of service, including any past due balance from a prior date of service. If the patient is a minor child, the parent or other adult accompanying the child will be financially responsible regardless of legal guardianship. Returned checks will be subject to fees.

**Medicare:** The office will bill the Medicare intermediary. Patients are responsible for the following:

- Annual Medicare deductible
- All applicable co-pays of the allowed charge
- Any non-covered services
- Any covered service ordered by the physician which does not meet Medicare's medical necessity and for which the beneficiary signed an Advanced Beneficiary Notice (ABN)

**Medicare Supplemental and Secondary Insurances:** The Practice will bill both Medicare and secondary insurances.

**Medicaid:** Patients must provide the Practice with a current Medicaid card at each visit. Medicaid patients are responsible for applicable co-pays and for all non-covered services. Medicaid patients are responsible for securing necessary referrals from their primary care physicians.

**HMOs and PPOs, Commercial Insurance Plans:** Patients are responsible for payment of the co-pay, co-insurance and/or deductible, or non-covered amounts at the time of service as well as for any charges for which the patient failed to secure prior authorization, if authorization is necessary. Insurance is filed as a courtesy and benefits are authorized to be paid directly to the Practice. Patients are responsible for the balance in full if not paid by the insurance within 30 days. If the patient is not prepared to pay the co-pay or deductible, a member of the clinical staff will determine if it is medically necessary for the patient to see the physician. If the patient's condition allows, the appointment will be rescheduled.

**Self-Pay:** Patients are responsible for payment in full at the time of services for all services rendered.
**Worker's Compensation:** Employer authorization must be obtained before treatment is rendered or the patient will be responsible for payment in full at the time of services for all services rendered. Once authorized, patients are not responsible for any charges unless the workers compensation case is dismissed or denied.

**Personal Injury/Motor Vehicle Accidents and Other Third Party Liability:** The patient is responsible for the balance in full at the time of service. Any settlement you receive from your insurance company or other third party will be handled by you, your insurance company, and/or your attorney.

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**Out of State Insurance:** If the patient presents with an out of state HMO/PPO insurance card, we will need to verify the patient's benefits for out-of-state or out-of-network benefits. The patient may be required to make payment in full or pay any co-pay, co-insurance or deductible.

**Authorizations and Consent**

**ASSIGNMENT AND RELEASE**: I hereby assign my insurance or other third party carrier benefits to be paid directly to the Physician Practice, realizing I am responsible for any resulting balance. I also authorize the Physician to release any information required to process this claim to my insurance carrier and/or to my employer or prospective employer (for employer sponsored/paid for claims). I acknowledge that I am financially responsible for services rendered, and failure to pay any outstanding balances may result in collection procedures being taken. Further, I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts of mine, or to a family member whose account I am guarantor for.

**ELECTRONIC CHECK CONVERSION:** When you provide a check as payment, you authorize us either to use information from your check to make a onetime electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account the same day.

**CONSENT FOR TREATMENT:** I hereby authorize the physicians, midlevel providers, nurses, medical assistants, and other Practice staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

**NO SHOW POLICY:** I understand if I fail to come for a scheduled appointment or cancel at least 24 hours prior to the appointment, I will be considered a "no show" and may be subject to a "no show" charge per occurrence. Ongoing occurrences of no shows may result in dismissal from the Practice.

I understand the Financial and No Show Policies, Authorizations and Consent for Treatment, and hereby agree to them:

_______________________________________ ____________________

**Patient or Parent/Guardian if Minor Name** Date

______________________________________

Signature