Urgent Care of Hanford
1028 N. Douty St. Ste. #1
Hanford, CA 93230
PH: 559-530-2526 Fax: 559-410-8215

Patient Information

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

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Cell #: _____ **Home #:** _____ **SSN #:** _____ required

E-Mail Address: _____ **Primary Care Physician:** _____

Occupation: _____ **Employer:** _____ **Work Phone:** _____

Emergency Contact: _____ **Phone Number:** _____ **Relationship:** _____

Who or what may we thank for you referral (Please Circle One) Drive by signage Family or friend Physician Insurance company Internet Other: _____

Responsible Party/Guarantor (insurance holder for patients under 18 years of age)

Last Name: _____ **First Name:** _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Phone: _____ **SSN** required: _____ **Relationship to Patient:** _____

Insurance Information

Self Pay/ No Insurance
Self Pay/ Do not bill insurance
Card Provided
Primary Insurance Company _____ ID Number: _____
Group #: _____
Secondary Insurance Company _____ ID Number: _____
Group #: _____

Verification of Information/ HIPAA Notice of Privacy

I verify that the above information provided is true and correct to the best of my knowledge. I hereby authorize the facility to accept assignment of insurance benefits and I understand that I am responsible for coinsurance, copayments, and/or deductibles at the time of service. I understand that if my insurance is a non-contracted plan (out of network); the facility will courtesy file the claim for services rendered. In the event that I have no insurance coverage, I understand that the fees are due at the time of service. I understand that the previous balances owed to the facility will be requested at the time of registration. Signature below is only acknowledgement that you have received the Notice of our Privacy Practices.

_____ _____
Authorized Signature of Patient/Guardian/Accompanying Adult Date

Consent for Treatment

I hereby consent to medical evaluation, testing, and/or treatment provided to me by the staff of this facility which may also include medical and minor surgical treatment or procedures, emergency treatment, and laboratory procedures. I understand that this medical facility may use or disclose Protected Health Information (PHI) necessary to carry out treatment, payment, or healthcare operation. I authorize release of any information concerning me or my child's healthcare, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize the facility to e-prescribe my prescriptions. For treatment purposes, the facility may request and utilize my medication history from other healthcare providers or third party pharmacy benefit payers. I acknowledge that if the provider has ordered additional laboratory testing that the collected specimens will be sent to a local laboratory for testing. The facility will forward your payer information to the laboratory but you will be responsible for the charges incurred for these services and will receive a separate bill from the laboratory. I understand that there may be a portion of the cost of Durable Medical Equipment that is not covered by my insurance and I will be responsible for the balance. Please notify staff of any barrier to effective communication or educational instruction that would prevent the understanding of information about the patient's health status, treatment, or the informed decision making process, such as foreign language, hearing or speech impairment, difficulty with reading or writing, or inability to comprehend verbal instruction.

_____ _____

Authorized Signature of Patient/Guardian/Accompanying Adult Date

Waiver of Liability Form

Provider: This form is to be used for PPO, HMO and MEDICARE members who wish to receive health care services from Central Coast Urgent Care, Inc. in Hanford, that may not be covered by their PPO, HMO, Kaiser, Tri-Care, and MEDICARE benefit plan.
Member: Your signature on this form acknowledges that you agree to bear financial responsibility for all services provided as listed below
** The service(s) is not covered under your benefit plan, or
** The service(s) has not been otherwise approved for payment by your health plan, or
** The service(s) is not medically necessary, or
** The service(s) is primarily for comfort and convenience, or
** You choose to upgrade a product or service(s) above the level otherwise covered under your health plan you will pay the difference between the billed amount and allowed amount.

Services: (Any service not described as a covered benefit in the members Evidence of Coverage Disclosure Form)

**In addition to being responsible for the amount, I understand I will be billed and held responsible for any applicable co-payment of deductible. I understand I will be billed and held responsible for any applicable weekend, holiday and after hour charges not paid by my insurance.

_____ _____ _____

Print Name Signature Date

Name: _____ **Today's Date:** _____ **Birth Date:** _____

Age: _____ **Sex:** _____ **Occupation:** _____

Marital Status (Circle One): Single Married Widowed Divorced Other

Chief Complaint (why you are here): _____

Duration (how long have you had this problem): _____

What treatments have you attempted for this problem: _____

Preferred Pharmacy: _____

Have you previously or do you currently have any of the following:

YES	NO		YES	NO		YES	NO	
☐	☐	Diabetes	☐	☐	Hypertension	☐	☐	Acute Infections
☐	☐	Cancer	☐	☐	Stroke	☐	☐	Venereal Disease
☐	☐	Heart Trouble	☐	☐	Arthritis/Gout	☐	☐	Hereditary Disease
☐	☐	Convulsions	☐	☐	Bleeding Tendency	☐	☐	Other: _____

Previous Hospitalizations/Surgeries/Serious Injuries: **Date:**

_____ _____

_____ _____

_____ _____

Are you allergic to any of the following:

☐ Penicillin	☐ Sulfa	☐ Mycins	☐ Food Allergies: _____
☐ Codeine	☐ Morphine	☐ Aspirin	_____
☐ Mercury	☐ Iodine	☐ Tetanus	☐ Other: _____
☐ Adhesive Tape	☐ Latex	☐ Cosmetics	_____

Date of Last Tetanus: _____

Current Medications: _____

_____

_____

Do you use any of the following:

Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Tobacco: ☐ Never ☐ Yes. Pack(s) per day: _____ for _____ years. ☐ Quit. Date quit: _____

Drugs: ☐ Never ☐ Yes. Type/Frequency: _____

Family Medical History:

	Age:		Diseases:	Deceased:	Cause of Death:
Father:	_____		_____	☐	_____
Mother:	_____		_____	☐	_____
Siblings:	_____	M or F	_____	☐	_____
	_____	M or F	_____	☐	_____
	_____	M or F	_____	☐	_____
Children:	_____	M or F	_____	☐	_____

A. Central Coast Urgent Care, Inc.
B. Patient Name: **C. Patient ID Number or DOB:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
EKG Ear Lavage Strep Test Tetanus Urinalysis	Medicare deems the procedure or labwork is unnecessary	$25 $50 $20 $40 $5

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.