OCCUPATIONAL MEDICINE+ Urgent Care

Thank you for selecting our healthcare team!

To help us meet your healthcare needs, please fill out this form completely.

Date: _____ **Chart #:** _____

Patients Name: First _____ **MI** _____ **Last** _____

Gender _____ **Birthdate** _____ **Social Security Number** _____

Patient's Address _____

City _____ **State**_____ **Zip** _____

Email Address _____

Mailing Address (if different from above) _____

_____

Phone: Home _____ **Cell** _____ **Work** _____

Marital Status (Circle One) Single / Divorced / Married / Separated / Widowed

Race (Circle One) American Indian or Alaskan / Asian / Black or African American

Native Hawaiian / White / Other

Ethnicity (Circle One) Hispanic or Latino Not Hispanic or Latino

Preferred Language _____

Preferred Pharmacy Name _____

Preferred Pharmacy Number _____

Emergency Contact / Release of Information

Name: _____

Relationship to Patient: _____ Phone _____

Name: _____

Relationship to Patient: _____ Phone _____

Additional Person for Release of Information

Purpose: To ensure authorization that releases Occupational Medicine Plus Urgent Care to speak with additional persons regarding patient care.

I, _____, patient of Occupational Medicine Plus Urgent Care, authorize the following individuals to be able to discuss and/or appointments at Occupational Medicine Plus Urgent Care with any specializing physician to which I am referred and/or currently seeing, and their clinical staff, as well as any insurance or billing issues.

I also authorize the staff of Occupational Medicine Plus Urgent Care to be able to discuss my care/appointments at Occupational Medicine Plus Urgent Care with the following persons:

Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

X_____ _____
SIGNATURE OF PATIENT AND/OR REPRESENTATIVE **DATE**
WITNESS _____

Responsible Party (If Different from Patient)
Name: _____ Relationship to Patient _____
Address _____ DOB _____
_____
Phone _____ Cell _____ Work _____
Employer Name _____
Employer Address _____

Primary Insurance (Please provider insurance card for us to copy)
Co-Pay Amount $ _____
Primary Insurance Company _____
Name of Insured (as it appears on the card) _____
SS#_____
Subscriber Name _____ Date of Birth _____
Relationship to Patient _____
Policy # _____ Group # _____
Employer Name _____
City _____

Secondary Insurance (Please provide insurance card for us to copy)

Co-Pay Amount $ _____

Primary Insurance Company _____

Name of Insured (as it appears on the card) _____

SS#_____

Subscriber Name _____ Date of Birth _____

Relationship to Patient _____

Policy # _____ Group # _____

Employer Name _____

City _____

GUARANTEE OF ACCOUNT

Occupational Medicine Plus Urgent Care (OMUC) requests payment for co-pays and deductibles at time of service. Your contract with your insurance carrier, depending on the type on insurance and the carrier, states that you are responsible for co-pays and deductibles at the time of service and Occupational Medicine Plus Urgent Care also has an agreement with your carrier to collect such fees at time of service. If your carrier has not paid your account with OMUC within 60 days we ask that you pay the balance and seek settlement direct form your carrier.

If you are not covered by health insurance, please ask about our cash payment at time of service.

I hereby authorize and assign payment directly to Occupational Medicine Plus Urgent Care and its practitioners for any medical/surgical benefits, injury benefits due because of third party liability, or proceeds of all claims resulting form the liability of the third party until such time as the account is paid in full upon the completion of treatment. By signing this form, I accept responsibility for reasonable costs incurred if my account becomes delinquent. I have read, understand and agree with the above.

X_____ _____

SIGNATURE OF PATIENT AND/OR REPRESENTATIVE **DATE**

PATIENT SIGNATURE AUTHORIZATION / REALASE OF INFORMATION

I hereby consent to and authorize Occupational Medicine Plus Urgent Care to furnish any insurance company, organization, hospital, physician, or pharmacist any information requested with respect to any physical or mental condition and/or treatment of me and my child.

I understand the information obtained by this authorization will be used to determine eligibility for insurance and eligibility for benefits under my insurance coverage. Any information will not be released except to persons or organizations performing business or legal services in connection with the claim, or as may be otherwise lawfully required or as I may further authorize.

I agree that this authorization shall be valid until rescinded in writing or replaced by one at a later date.

X_____ _____

SIGNATURE OF PATIENT AND/OR REPRESENTATIVE **DATE**

CONSENT FOR MEDICAL / EMERGENCY TREATMENT

I hereby consent to and authorize Occupational Medicine Plus Urgent Care personnel or its contractors to render usual and customary medical/emergency treatment to me. I understand the treatment provided will be in accordance with the standard of care at the time the care is provided, including but not limited to office visits, and interpretations of x-rays, EKG, and/or laboratory results.

X_____ _____

SIGNATURE OF PATIENT AND/OR REPRESENTATIVE **DATE**

WITNESS _____

ACKNOWLEDGEMENT TO USE AND DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand and have been offered an Occupational Medicine Plus Urgent Care Notice or Privacy Practices that provides a more complete description of information uses and disclosures; that I have the right to review the notice prior to signing this acknowledgement; that Occupational Medicine Plus Urgent Care reserves the right to change its notice and practices.

X_____ _____

SIGNATURE OF PATIENT AND/OR REPRESENTATIVE **DATE**

WITNESS _____

PAYMENT OF MEDICARE BENEFITS TO PROVIDER EXTENDED AUTHORIZATION

I certify that the information given by me in applying the payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made directly to Occupational Medicine Plus Urgent Care on my behalf.

X_____ _____

SIGNATURE OF PATIENT AND/OR REPRESENTATIVE **DATE**

WITNESS _____

PAYMENT OF MEDICAID BENEFITS TO PROVIDER EXTENDED AUTHORIZATION

I certify that the information given by me in applying for payment under the Title XIX of the Social Security Ace is correct. I authorize any holder of medical or other information about me to release to the State of Alabama and its fiscal agents any information needed for this or a related Medicaid Claim. I request that payments of authorized benefits be made directly to Occupational Medicine Plus Urgent Care on my behalf.

X_____ _____

SIGNATURE OF PATIENT AND/OR REPRESENTATIVE DATE

WITNESS _____

You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mail, using any email address you provide to use.

I/We have read the disclosure and agree that the Lender/Creditor may contact me/us as described above.

X_____ _____

Signature of Parent/Guardian Date

As a patient of Occupational Medicine Plus Urgent Care, please be aware that you may be referred to a health car facility and/or specialist. You are, however, free to choose to obtain health care services elsewhere from another provider of your choice, and you may request to be provided with a list of alternative providers, if any, that may b available.

Private Insurance:

Insurance provider networks often add or delete insurance companies. Therefore, we suggest that you contact yo insurance company to verify their participation. You will be responsible for any out of network balance.

Medicare Policy:

As a courtesy to our patients, Occupational Medicine Plus Urgent Care accepts Medicare assignment. We will file claims to Medicare for you and hold billing until after Medicare has responded to the claim. Medicare will pay 80% their allowable, and the patient, or their secondary insurance, is responsible for the remaining 20%. Naturally, you Medicare deductible must be met first.

If you supply our office with the correct billing information, we will also file with your secondary insurance carrier a one-time basis. If your secondary insurance carrier does not pay within 60 days, you will then be responsible for balance.

Treatment of a Minor:

If the patient is a minor (under 19 years of age), the parent or guardian must sign below in addition to the authorization of treatment. The parent, guardian, or unaccompanied minor is responsible for any payment due at time of service, and providing required referrals, insurance, and picture ID cards.

Additional Charges:

- Forms: $15 (each form)
- For returned checks - $40

The undersigned certifies that he/she has read and understands the foregoing, is the patient or is duly authorized by the patient to execute the above, and accepts the terms therof.

_____ _____

Signature of Patient/Responsible Party **Date**

_____

Relationship to Patient

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently.

Do you currently use tobacco? _____ Age began using? _____

What type do you use? _____ If cigarettes – packs per day? _____

Do you consume alcohol? _____ How often? _____

Marital Status ___Married ___Single ___Divorced ___Widowed

Number of children _____

Last menstrual cycle _____ Could you be pregnant? _____

FAMILY HISTORY: if you have a family member with the following: Unknown / Adopted

	Father	Mother	Brother	Sister	Son	Daughter	Other
AIDS/HIV							
Anemia							
Blood Clots							
Cancer (Breast)							
Cancer (Colon)							
Cancer (Lung)							
Cancer (Prostate)							
Coronary Artery Disease							
Diabetes							
Gout							
Heart Attack							
Hemophilia							
Hypertension							
Kidney Disease							
Liver Disease							
Muscle Disease							
Osteoarthritis							
Osteoporosis							
Rheumatoid Arthritis							

OCCUPATIONAL MEDICINE+ Urgent Care

Today's Date: _____

Patient Name: _____ **DOB**_____

Age _____ **Gender** _____**Male** _____**Female**

MEDICAL HISTORY: PLEASE CIRCLE any of the following you may have:

ADD/ADHD
AIDS/HIV
Alzheimer's
Anemia
Anxiety
Asthma
Blood Clot/DVT Leg
Blood Clot/DVT Lung
Cancer: Colon Heart
Cancer: Breast
Cancer: Lung
Cancer: Prostate
Colitis / Crohn's
COPD / Emphysema
Defibrillator
Depression
Diabetes
Drug Abuse
Hepatitis / Jaundice
High Blood Pressure
Hypothyroid
Kidney Disease
Lupus
Migraine
Pacemaker
Psoriasis
Rheumatoid Arthritis
Scoliosis
Seizures
Sleep Apnea
Stomach Ulcers
Stroke

SURGICAL HISTORY: PLEASE CIRCLE any of the following you may have:

Appendectomy
Arthroscopy: Shoulder
Arthroscopy: Knee
Bunion
Vascular Surgery
Cardiac Stent
Carpal Tunnel Release
Gall Bladder
Gastric Bypass
Heart Surgery
Hip Replacement
Hysterectomy
Knee Replacement
Mastectomy
Spinal Surgery

ALLERGIES: Please List any medication allergies:

_____ _____

_____ _____

_____ _____

Are you allergic to latex? _____

REVIEW OF SYSTEMS: If you have any of the following, PLEASE CIRCLE.
Please make a selection for EACH BOX.

CONSTITUTIONAL Weight Loss / Gain Weakness Loss of Appetite NONE	**ENDOCRINE** Thyroid Trouble Low Blood Pressure Excessive Thirst NONE	**CARDIOVASCULAR** Chest Pain Irregular Heartbeat Swelling of legs/feet NONE	**GASTROINTESTINAL** Rectal Bleeding Gallbladder Trouble Liver Problems NONE
HEMATOLOGICAL Bleeding Problems Easy Bleeding Easy Bruising NONE	**HEENT** Blurred Vision Hoarseness Ears Ringing NONE	**INTEGUMENTARY** Rashes Skin Ulcers Changes in Skin NONE	**RESPIRATORY** Shortness of Breath Pain when Breathing NONE
GENITOURNINARY Bladder Problems Incontinence Kidney Stones Burning Urination NONE	**MUSCULOSKELETAL** Joint Pain Cramps Limitation in Activity Muscle Pain NONE	**MENTAL HEALTH** Nervousness Depression Sleep Disorder Fainting Spells NONE	**NEUROLOGICAL** Headache Dizziness Seizures Numbness/Tingling Faintness NONE

I hereby certify by my signature that the medical information given on this form is correct to the best of my knowledge.

Patient Signature _____ **Date**_____

OCCUPATIONAL
MEDICINE+
Urgent Care

Patient Name ____________________________________ DOB ______________________

Medication Name	Strength/Dose	Directions	Misc

OCCUPATIONAL MEDICINE+ Urgent Care

PHONE: (256)400-4210

FAX: 256-400-5665

rwright@occmeduc.com

7419 US Hwy 431 Suite B Albertville, AL 35950

ALABAMA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This authorization for use or disclosure of Protected Health Information is intended to satisfy the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and the Alabama Department of Public Health Office of Emergency Medical Services Rule 420-2-1-.13. Please review and complete the authorization form carefully. Failure to provider all of the requested information may invalidate the authorization.

Patient Name (first middle last): _____

Date of Birth: _____ SSN: _____ Phone Number: _____

Address: _____

Information Requested From

Name: _____ Phone: _____

Address: _____ Fax: _____

Send Information to

Name: _____ Phone: _____

Address: _____ Fax: _____

Format of Record Release

I request the record to be released in the following manner:

- o In Person
- o Mail
- o Email
- o Fax

Limitation on the Type of Information to Disclose:

- o No limitations on the type of information to disclose.
- o Limited to: _____

Expiration:

- o _____ Days from date signed
- o Date _____
- o 60 days from date signed

Patient Authorization

By submitting this form, I hereby voluntarily authorize the release if this medical record. As the patient, If I am authorizing the release of my medical record to the representative noted above, I understand that the release only pertains to the disclosure of the record described herein. This authorization shall expire immediately after the disclosure. I also understand that information used or disclosed may be subject to re-disclosure by the person, agent, class of persons or facilities receiving it, and may no longer be protected by state and federal confidentiality laws. If you are the parent of a minor and represent as such, you agree to hold Occupational Medicine Plus Urgent Care harmless for damages regarding the disclosure. I hereby understand and agree that requests for electronic copies of my medical records in electronic form via email may not remain confidential due to the unsecure nature of email transmission. I further understand and agree that employees and/or agents are not liable in any manner for the disclosure of information transmitted via email request, by virtue of electronic disclosure through an unsecured email system. I understand that I have the right to revoke this authorization at any time. The revocation must be made in writing and will not affect information that has already been disclosed.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____