ACCESS 365 Urgent Care

PATIENT REGISTRATION FORM

REASON FOR TODAY'S VISIT

☐ New Patient ☐ Returning Patient

Chief Complaint – Please describe your Symptom(s) here or check a box below (if applicable)	Referred By:	Date:

☐ Medical Treatment (list symptoms above)
☐ Work Related Injury – Worker's Compensation
☐ Car Accident or Auto Related Injury
☐ Pre-op Medical Clearance

Physicals:
☐ School Physical
☐ Work Physical
☐ DOT Physical

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Date of Birth
			_____ /_____ /_____ MM DD YEAR

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partner

☐ **I am a returning patient, there are NO changes to my personal and insurance information in the last 3 months. (Note: If you checked this box, you do not have to fill out the below.)**

Address:	Apt.	Social Security No.
City:		Employer:
State:	Zip Code:	**Employment Status:** ☐ Full Time ☐ Part Time ☐ Retired ☐ Self Employed ☐ Student ☐ Not Employed

Home Phone:	Cell Phone:	Race:	Ethnicity:	Preferred Language:
(_____) _____ - _____ Okay to leave voice message? ☐ YES ☐ NO	(_____) _____ - _____ Okay to leave voice / text message? ☐ YES ☐ NO	☐ White ☐ Asian ☐ African American ☐ Other_____	☐ Hispanic / Latin ☐ **Not** Hispanic / Latin	☐ English ☐ Spanish ☐ Other_____

Work Phone:	**Email:**
(_____) _____ - _____	To be used for provider communication, follow up, patient portal and other Access 365 related material. We DO NOT share email information with other parties). You may choose to remove at any time.
Extension:	

PRIMARY INSURANCE COMPANY / RESPONSIBLE PARTY

Insurance Company:				
Name of Policy Holder/Responsible Party:	**Policy Holder's Date of Birth:**	Month	Day	Year
Policy Holder's Social Security:	Policy Holder's Relationship to Patient:			
Subscriber Number:	Group Number:			
Check here if **Secondary Insurance** applies: ☐	Secondary Name:			
Secondary Policy Holder/Responsible Party:	**Secondary Policy Holder's DOB:**	Month	Day	Year
Second Policy Subscriber Number:	Seondary Policy Group Number:			

PATIENT PREFERENCE REGARDING COMMUNICATION OF MEDICAL INFORMATION

I hereby give permission to disclose and discuss any information related to my medical condition(s) with the following family member, relative, or other person:

NAME	*RELATIONSHIP*	*PHONE NUMBER*
****NOTE**: This individual will be listed as your emergency contact.**		

I hereby **give permission to disclose and discuss** any information related to **my medical condition(s)** with the following family member, relative, or other person:

NAME	*RELATIONSHIP*	*PHONE NUMBER*

▶ PLEASE SIGN HERE: PATIENT OR GUARDIAN:_____ **DATE:**_____

ACCESS 365 URGENT CARE CENTER

PRIVACY & BILLING PROCEDURES
AUTHORIZATION & ACKNOWLEDGEMENT

These authorizations, acknowledgements and waivers cover all services rendered to the above patient for today and all futures dates of service. You may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any events that occurred before you notified us of your decision to revoke.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Access 365 Urgent Care Center reserves the right to modify the privacy practices outlined in the Notice of Privacy Practices. I have had the opportunity to read or have received a copy of the Notice of Privacy Practices for the Patient outlined above.

AUTHORIZATION TO TREAT & BILL

I give consent and authorization to Access 365 Urgent Care Center to examine and provide all routine medical care, diagnostic procedures, disposing of any specimens or tissue taken from my body, and provide treatment which provide in the judgment of the medical provider, may be necessary or beneficial to my health and well-being with no guarantees expressed regarding the results of examination and treatment by aforementioned facility.

I authorize the release of any medical and demographic information necessary to process all claims. I authorize payment of medical benefits to Access 365 Urgent Care Center for all services performed.

I understand that I am responsible for all charges incurred at the time of service unless other arrangements were made prior to being treated. I will pay any deductible, co-payment, co-insurance, and any amounts denied or not covered by insurance. I understand it is my responsibility to check with my insurance carrier prior to my visit for covered and non-covered benefits and whether or not Access 365 Urgent Care Center visit will be paid with my in-network or out-of-network benefits billed as urgent care place of service (POS 20).

I understand that if I do not provide complete and accurate billing/Insurance information at the time of service and this lack of information prevents Access 365 Urgent Care Center from collecting from my insurance company, I will be responsible for the full charges. If a referral or additional forms are required by my insurance company, I understand I am responsible for providing Access 365 Urgent Care Center with a referral within 48 hours of my visit and/or complete all insurance required forms in a timely manner, or I may be responsible for all charges.

Interest: Invoices and bills for treatment will bear interest at the rate of 18% per annum (1.5% per month) 30 (thirty) days after the date of service until fully paid.

Collection Fees: If payment is not made as agreed upon, the account will be turned over for collection. The patient, and/or guarantor, shall be responsible for and agree to pay all reasonable cost of collection including, but not limited to, reasonable collection agency fees, attorney's fees, and court costs.

Jurisdiction and Venue: If any suit must be filed to collect an unpaid balance on an account, patient, and/or guarantor, agrees that such suit may be brought in courts of Martin County, Florida, and waives any objection to jurisdiction or venue.

Assignment & Release: I hereby request and assign directly to Access 365 Urgent Care Center all medical benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, including collection fees and/or interest that may accrue, whether or not paid by insurance. I hereby authorize the Provider to release all information necessary to secure the payment of benefits unless written notice is given to revoke this authorization. I authorize the use of a copy of this signature is as valid as the original signature on all of my insurance submissions. Co-pays and/Quick Pay fees are due at the time of service. All account balances will be the patient's and/or guarantor's responsibility after processing of insurance, if applicable, and may be assessed a $15.00 statement fee per invoice. Full balance is due within 15 days or upon receipt of the first invoice. If you have signed the convenient EZPAY form, you will receive an invoice with the balance due after insurance submission. If the invoice is not paid within 10 days and you do not contact us with an alternate form of payment, the signed EZPAY will be used to bring the account up to date. If card is declined, a $15 fee may apply. Access 365 Urgent Care Center is not responsible for any overdraft fees if a bank card is provided as EZPAY.

► **PLEASE SIGN HERE:** PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE: _____ DATE: _____

OUTSIDE LABORATORY AND RADIOLOGISTS

It is my understanding that Access 365 Urgent Care Center may send lab specimens to an outside laboratory or send x-rays taken by Access 365 Urgent Care Center to an outside Radiologist for over reading. I give permission for those outside laboratories and radiologists to bill my insurance for their services. I understand that I may incur additional charges as a result of those outside laboratory tests or radiologists. I understand that Access 365 Urgent Care Center is not responsible for payment to those laboratories and/or radiologists.

► **PLEASE SIGN HERE:** PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE: _____ DATE: _____

NON-COVERED SERVICES

It is my understanding that my insurance company may deem my visit to Access 365 Urgent Care Center as a non-covered service and may make me fully responsible for payment of all charges for these services. _____

► **PLEASE SIGN HERE:** PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE: _____ DATE: _____

ACCESS 365 Urgent Care

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, _____ (first name and last name), _____ (date of birth), hereby give my permission to Access 365 Urgent Care to release the following information (check all that apply):

- ☐ My complete medical records (incl. all lab reports and radiology reports)
- ☐ Lab test results
- ☐ HIV, AIDS and other communicable disease test results
- ☐ Radiology reports/exams
- ☐ Original x-ray films (films remain Access 365 property and must be returned within 30 days)
- ☐ Other: _____

Please indicate where we should send copies of the information above: _____

_____
(include name, organization, telephone number, fax number and mailing address).

The above information is being released for the purpose of: _____
(unrestricted and unlimited purpose if left blank)

Expiration Date of Authorization: This authorization is effective for one year from the date signed or until _____/_____/_____, unless revoked or terminated earlier by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization: You may revoke or terminate this authorization by submitting a written revocation to Access 365 Urgent Care. You should contact the Privacy Management Official to terminate this authorization.

Potential for Re-disclosure: I understand my information may be mailed, faxed or picked-up in person. The person or organization sent or transporting the disclosed information under this authorization may disclose information again. It may not be possible to ensure your right to the protection of the privacy of this information once Access 365 releases/discloses it to another party.

Rights of the Individual: You may inspect or copy information used or disclosed under this authorization. You may refuse to sign this authorization.

Effect of Refusing Authorization: If you refuse to sign this authorization, Access 365 Urgent Care will not deny you any treatment except treatment that you have requested for the purpose of disclosure to others.

SIGNATURE

_____	_____	_____
Signature	Patient Name	Date

_____	_____
Name of Patient Representative Signing for Patient (required if the patient is a minor or an adult who is unable to sign this form)	Relationship of Patient Representative to Patient

Health Information

ACCESS 365 Urgent Care

Patient Name: _____

Lifestyle

- Alcohol Use: # of drinks per week_____
- Smoking: ❑ Never smoked
  - Current Smoker: PPD_____ # of years_____
  - ❑ Former Smoker: Quit Date_____ # of years used _____ PPD _____
  - ❑ Smokeless Tobacco
- Do you exercise regularly? If so, please state what type and frequency. _____

Medical History— Please check all that apply

❑ AIDs/HIV Positive	❑ Eye Problems	❑ Hypoglycemia	❑ Shortness of Breath
❑ Arthritis	❑ Fainting/Syncope	❑ Joint Pain	❑ Stomach Conditions
❑ Asthma	❑ Glaucoma	❑ Kidney Disease	❑ Stroke
❑ Autoimmune Conditions	❑ Headaches	❑ Low Blood Pressure	❑ STDs:
❑ Back Pain	❑ Hearing Impairment	❑ Memory Loss	❑ Tuberculosis
❑ Bronchitis	❑ Heart Disease	❑ Pain or Pressure in Chest	❑ Thyroid Disorder
❑ Cancer (type?)	❑ Heart Murmur	❑ Palpitations	❑ Urinary Tract Infections
	❑ Hemodialysis	❑ Pneumonia	0 Use of Blood Thinners
❑ COPD	❑ Hepatitis	❑ Reflux	❑ Other:
❑ Dementia/Alzheimer's	❑ High Cholesterol	❑ Rheumatism	
❑ Diabetes	❑ High Blood Pressure	❑ Seizures/Epilepsy	

Surgical History - Please check all that apply

❑ Angioplasty	❑ Colostomy	❑ Joint Replacement	❑ Spinal Fusion
❑ Arthroscopy	❑ Gallbladder Removal	❑ Larninectorny	❑ Tonsillectomy
❑ Appendectomy	❑ Gastric Bypass	❑ Lumpectomy	❑ Thyroid
o Back Surgery	❑ Glaucoma Surgery	❑ Lung Surgery	❑ Tubal Ligation
❑ Biopsy (site):	o Heart Bypass	❑ Pacemaker/Defibrillator	❑ Vascular Surgery
❑ Breast Surgery	❑ Heart Valve	❑ Plastic Surgery	❑ Vasectomy
❑ Cataract Removal	❑ Hysterectomy	❑ Radiation	❑ Other:
❑ Cardiac Catheter	❑ Intestinal Surgery	❑ Skin Lesion Removal	❑

Family History - Please check all that apply and specify which relative

❑ Alcoholism	❑ Heart Condition	❑ Seizures
❑ Arthritis	❑ Hemodialysis	❑ Stomach or GI Problems
❑ Asthma	❑ Hepatitis	❑ Stroke
❑ Cancer (type?)	❑ High Blood Pressure	❑ Thyroid Disorders
❑ COPD	❑ High Cholesterol	❑ Other:
❑ Diabetes	❑ Kidney Disease	❑
❑ Glaucoma	❑ Memory Problems	❑

Preventive Tests and Screenings

❑ Physical Exam	❑ EKG	❑ Pap Smear	❑ PSA
❑ Labs	❑ Cardiac Stress Test	❑ Mammogram	❑ Bone Density
❑ Eye Exam	❑ Colonoscopy	❑ Bone Density	❑ Skin Cancer Screen

ACCESS 365 Urgent Care

Ownership Notice to Patients

Because of concerns that there may be a conflict of interest when a physician refers a patient to a health care facility in which the physician has an ownership interest, Florida passed a law (the "Patient Self-Referral Act of 1992", FL Statute Section 455.654.)

Under this law, I must disclose my ownership in this facility and tell you about alternative places where you may go to obtain these services. This disclosure is intended to help you make a fully informed decision about your health care. You have the right to obtain healthcare items or services at a location or from a provider or supplier of your choice, including the facility in which I am owner. I assure you that you will not be treated differently if you do not choose the facility listed below in which I have an ownership interest.

Dr. Robert McLaughlin

Has an ownership interest in: Back In Action Medical Center, LLC, Proactive Health and Wellness, DBA Back in Action Chiropractic, and Access365 Urgent Care.

Alternative Medical facilities in which we do not have ownership:

1. Martin MediCenter of Palm City
2. MedStat
3. Treasure Coast Urgent Care and Family Medicine

Alternative Chiropractic facilities in which we do not have ownership:

1. Loving Chiropractic of Stuart Florida
2. Life Chiropractic
3. Merritt Family Chiropractic

Patient Name: _____

Signature: _____ Date: _____

If not patient, name of legal guardian: _____ Relationship: _____

Access 365 Urgent Care

Acknowledgement of Receipt of Privacy Notice
Authorization for Treatment and Financial Agreement

I have been offered a written copy of Access 365 Urgent Care's **Notice of Privacy Policies,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand my rights as described in this notice.

I hereby apply for treatment by Access 365 Urgent Care, physicians and/or their assistants. Such treatments include injections and such other office procedures as they deem medically necessary.

Further, I permit a copy of this authorization to be used in place of this original, and authorize the filing of any insurance claims in force and direct payment to Access 365 Urgent Care, of any amounts due. I understand I am financially responsible for charges not covered by benefits due under this authorization and accept full responsibility for such charges. Regulations pertaining to medical assignment of benefits apply. I further understand that should my insurance have a copay, I am required to pay it on the day of service.

If I do not sign this consent, or later revoke it, Access 365 Urgent Care may decline to provide treatment to me.

Patient Name: _____

Signature: _____ Date: _____

If not patient, name of legal guardian: _____ Relationship: _____

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement of receipt of notice and/or consent to disclose PHI, please document date and time the notice was presented to patient and sign below.

Presented on (date & time): _____ By (name & title): _____

ACCESS 365 URGENT CARE
HIPAA NOTICE OF PRIVACY PRACTICES
Effective Date: July 1, 2017

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this notice, please contact: Access 365 Urgent Care at (772) 222-5302. This notice describes the privacy practices at our office.

We are required by law to:

- Maintain the privacy of protected health information.
- Give you this notice of our legal duties and privacy practices regarding your health information.
- Follow the terms of the notice currently in effect.

How we may use and disclose your health information:
Described as follows are the ways we may use and disclose your health information. Except for the following purposes we will use and disclose your health information only with your written permission. You may revoke such permission at any time by writing to Access 365 Urgent Care.

Treatment:
We may use and disclose your health information for your treatment and to provide you with treatment-related health care services. For example, we may disclose your health information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment:
We may use and disclose your health information so that others or we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give information to your health plan so that they will pay for your treatment.

Health Care Operations:
We may use and disclose your health information to evaluate and Improve our medical care and to operate and manage our office. For example, we may use and disclose information to a peer review organization or a health plan that is evaluating our care. We may also share information with others that have a relationship with you for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services:
We may use and disclose your health information to contact you and remind you of your appointment on post-cards, to tell you about treatment alternatives or health-related benefits and services you could use.

Individuals Involved in Your Care or Payment for Care:
When appropriate, we may share your health information with a person involved in, or paying for, your care (such as your family or a close friend). We may notify your family about your location or condition or disclose such information to an entity assisting in disaster relief.

Research:
We may use and disclose your health information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we do so, the project needs to go through a special approval process. Even without special approval, we may permit researchers to look at records to help identify patients who may be included in their research, as long as they do not remove or copy any of your health information.

As Required by Law:
We will disclose your health information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety:
We may use and disclose your health information when necessary to prevent a serious threat to the health and safety of you, another person, or the public. Disclosures will be made only to someone who can prevent the threat.

Business Associates:
We may disclose your health information to our business associates that perform functions on our behalf or provide us with services if necessary. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose the information for any other purpose than appears in their contract with us.

Military and Veterans:
If you are a member of the armed forces, we may release your health information as required by military command authorities. If you are a member of a foreign military we may release your health information to the foreign military command authority.

Worker's Compensation:
We may release your health information for worker's compensation or similar programs that provide benefits for work related injuries or illness.

Public Health Risks:
We may disclose your health information for public health activities to prevent or control disease, injury or disability. We may use your health Information in reporting births or deaths, suspected child abuse or neglect, medication reactions *or* product malfunctions or injuries, and product recall notifications.

We may use your health information to notify someone who may have been exposed to *a* disease or may be at risk for contracting or spreading a disease or condition. If we are concerned that a patient may have been a victim of abuse, neglect, or domestic violence we may ask your permission to make a disclosure to an appropriate government authority. We will make that disclosure only when you agree or when required or authorized to do so by law.

Health Oversight Activities:
We may disclose your health information to a health oversight agency for activities authorized by law. These may include audits, investigations, inspections, and licensure. These activities are necessary to for the government to monitor the health care system, government programs & compliance with civil rights law.

Lawsuits and Disputes:
If you are involved in a lawsuit or dispute, we may disclose your health information in response to a court or administrative order. We may disclose your health information in response to a subpoena, discovery request, or other lawful process by someone else Involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement:
We may release your health information request by law enforcement official if:

1. there is a court order, subpoena, warrant, summons or similar process;
2. if the request is limited to information needed to identify or locate a
3. suspect, fugitive, material witness, or missing person;
4. the Information is about the victim of a crime even if, under certain
5. very limited circumstances, we are unable to obtain your agreement;
6. the information is about a death that may be the result of criminal conduct;
7. the information is relevant to criminal conduct on our premises; and
8. It is needed in an emergency to report a crime, the location of a crime or victims, or the identity, description, or location of the person who may have committed the crime.

Coroners, Medical Examiners, and Funeral Directors:
We may release your health information to a coroner, medical examiner, or funeral director to identify a deceased person or cause of death, or other similar circumstance.

National Security and Intelligence Activities:
We may disclose your health Information to authorized federal officials for intelligence and other national security activities authorized by law.

Inmates or Individuals in Custody:
If you are an inmate of a correctional institution or in custody we may disclose your information:

1. for the institution to provide you with health care,
2. to protect your health and safety or that of others, and
3. for the safety and security of the institution.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Inspect and Copy:
You have the right to inspect and copy your medical and billing records by written request to Access 365 Urgent Care.

Right to Amend:
You have the right to request an amendment to your records by written request to Access 365 Urgent Care.

Right to an Accounting of Disclosures:
You have a right to an accounting of certain disclosures by written request to Access 365 Urgent Care.

Right to Request Restrictions:
You have the right to request restriction or limitation on your health information used for treatment, payment or health care operations. You may request us to limit disclosure to someone involved in your care or in payment for your care (such as a spouse) by written request to Access 365 Urgent Care. We are not required to agree with your request, but we will try to comply.

Right to Request Confidential Communication:
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You can ask, for example, that we contact you only by mail or at work. Your written request must specify how or where you wish to be contacted and be addressed to Kent Rilling. We will accommodate reasonable requests.

CHANGES TO THIS NOTICE
We may change this notice and make it effective for medical information we already have about you as well as new information. The current notice will be posted and available at all times. You have a right to request a paper copy of the current notice at any visit or by written request to Access 365 Urgent Care.

ACCESS 365 Urgent Care

2339 SW Martin Highway
Palm City, Florida 34990
(772) 222-5302