

## REASON FOR TODAY'S VISIT

 **New Patient**
 **Returning Patient**

<b>Chief Complaint</b> – Please describe your Symptom(s) here or check a box below (if applicable)	Referred By:	Date:
<input type="checkbox"/> Medical Treatment (list symptoms above) <input type="checkbox"/> Work Related Injury – Worker's Compensation <input type="checkbox"/> Car Accident or Auto Related Injury <input type="checkbox"/> Pre-op Medical Clearance	<b>Physicals:</b> <input type="checkbox"/> School Physical <input type="checkbox"/> Work Physical <input type="checkbox"/> DOT Physical	

## PATIENT INFORMATION

Last Name	First Name	Middle Initial	Date of Birth MM / DD / YEAR
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Partner		

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City		Employer
State:	Zip Code:	<b>Employment Status:</b> <input type="checkbox"/> Full Time <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Part Time <input type="checkbox"/> Self Employed <input type="checkbox"/> Not Employed
Home Phone: ( ) - Okay to leave voice message? <input type="checkbox"/> YES <input type="checkbox"/> NO	Cell Phone: ( ) - Okay to leave voice / text message? <input type="checkbox"/> YES <input type="checkbox"/> NO	Race: <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Other _____ Ethnicity: <input type="checkbox"/> Hispanic / Latin <input type="checkbox"/> Not Hispanic / Latin Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____
Work Phone: ( ) -	<b>Email:</b> 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 <b>Secondary Insurance</b> applies: <input type="checkbox"/>	Secondary Name:			
Secondary Policy Holder/Responsible Party:	Secondary Policy Holder's DOB:	Month	Day	Year
Second Policy Subscriber Number:	Secondary 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: \_\_\_\_\_

# Health Information

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

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

## Surgical History - Please check all that apply

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

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

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

## Preventive Tests and Screenings

<input type="checkbox"/> Physical Exam	<input type="checkbox"/> EKG	<input type="checkbox"/> Pap Smear	<input type="checkbox"/> PSA
<input type="checkbox"/> Labs	<input type="checkbox"/> Cardiac Stress Test	<input type="checkbox"/> Mammogram	<input type="checkbox"/> Bone Density
<input type="checkbox"/> Eye Exam	<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> Bone Density	<input type="checkbox"/> Skin Cancer Screen



### 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: \_\_\_\_\_

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### **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.



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