Total Urgent Care

Patient Demographics

Last Name:_____ First Name:_____

Street:_____ Apt #:_____

City:_____ State:_____ ZIP:_____

Home Phone:_____ Cell:_____

Email:_____ SS #:_____

Date of Birth:_____/_____/_____ Age:_____ Sex: M_____ F_____

Single ___ Married____ Widowed___ Divorced____ Legally Separated____

Mother's Information (MINORS ONLY)

Last Name:_____ First Name:_____

Address:_____ Apt#:_____

City:_____ State:_____ Zip:_____

Father's Information (MINORS ONLY)

Last Name:_____ First Name:_____

Address:_____ Apt#:_____

City:_____State:_____Zip:_____

Pharmacy Name:_____ Location:_____

Pharmacy Phone:_____

Occupation:_____ Work Phone:_____

Employer's Name:_____

Primary Insurance:_____

ID #:_____ Group #:_____

Policy Holder's Name:_____ Date of Birth:_____

Policy Holder's SS#:_____ Relationship to Patient:_____

Secondary Insurance:_____

ID #:_____ Group #:_____

Policy Holder's Name:_____ Date of Birth:_____

Policy Holder's SS#:_____ Relationship to Patient:_____

Emergency Contact:_____

Phone #:_____ Relationship to Patient:_____

Today's Date:_____

Authorization for Use/Disclosure

Of Health Information

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize my health care provider TOTAL URGENT CARE to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):

Name:_____

Address:_____

Purpose: I authorize the release of my health information for the following specific purpose:

_____.

(Note: 'At the request of the patient" is sufficient if the patient is initiating this Authorization.)

Information to be disclosed: I authorize the release of the following health information:

(Check the applicable box below)

□ All of my health information that the provider has in his/her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

□ Only the following records or types of health information:

_____.

Term: I understand that this Authorization will remain in effect.

□ From the date of this Authorization until the ____ day of _____, 20____.

□ Until the Provider fulfills this request.

□ Until the following event occurs:_____

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

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[1] NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement or quality of my treatment at USC. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the USC Office of Compliance at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Questions: I may contact the USC Office of Compliance for answers to my questions about the privacy of my health information at 3500 Figueroa, Suite 105, Los Angeles, CA 90089-8007, or by telephone at (213) 740-8258.

_____	_____	_____
Signature	Date	Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

_____	_____	_____	_____
Name of Guardian/Representative	Legal Relationship	Date	Signature of Witness

Statement of Patient Financial Responsibility

Total Urgent Care

The doctors and staff of Total Urgent Care appreciate the confidence you have shown in choosing them to provide for your health care needs. We are committed to providing you with the best possible medical care. The service you have elected to participate implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our services. As a courtesy, we will bill your insurance carrier on your behalf. However, you are ultimately responsible for payment services and care received under the care of Totally Urgent Care, PLLC..

Payments

1. All co-payments, co-insurance and deductibles are due and payable PRIOR to services being rendered and is required by your insurance to be paid each visit.
2. If you do not know your co-pay we will collect a minimum fee of $30.00. Our billing department will bill or credit your account accordingly after your insurance pays their portion. If you are not prepared of unable to pay your co-payment prior to your visit, we will kindly reschedule your appointment for a more convenient time.
3. Overpayments will be refunded after all charges have been processed and paid by your insurance company. A refund check will be written and mailed within 30 days of your verbal or written request.
4. There is a $30.00 service charge on all returned checks. After receiving a returned check, Total Urgent Care will only accept cash, money order or credit card.

If you fail to meet financial obligations agreed upon in this financial policy or other payment arrangements made with Total Urgent Care, LLC., your outstanding balance will be sent to a collection agency and the complete balance will have to be paid before receiving any further treatment. Your future status with this office will be considered at that time and may lead to being discharged from Total Urgent Care, LLC.. If you have any questions, please contact Robin in the billing department at 586-745-0322.

Insurance

While the filling of insurance claim is a courtesy that we extend to our patients, it is your responsibility to:

1. Bring your insurance card to each visit
2. Notify our office of any changes to your insurance
3. Know your co-pay and be prepared to pay at each visit
4. Know your insurance company benefits and coverage
5. Determine if doctor(s) are network providers prior to visit
6. Pay for any amounts not covered by your insurance

I have read and understand Total Urgent Care LLC's Statement of Patient Financial Responsibility. I agree to assign insurance benefits to Total Urgent Care LLC. whenever necessary. I authorize Total Urgent Care LLC. to release information to a collection agency or attorney. In the event of nonpayment or default, I am responsible for all costs and reasonable collection and/or attorney fees. Total Urgent Care LLC. reserves the right to change or amend this statement at any time and at its discretion.

Signature of responsible party:_____

Print Name:_____

Date of Birth:_____ Today's Date:_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION

PLEASE REVIEW IT CAREFULLY

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters.)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

PATIENT ACKNOWLEDGE OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

_____ _____

Print Patient's Name Date

I, _____, acknowledge that I have either received a
(Signature of Patient or Parent or Legal Guardian)

copy of this office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available to me to receive.

I, _____, consent to the use and disclosure of
(Signature of Patient or Parent or Legal Guardian)

my personal health information by your office for Treatment, Billing/Payment and Health Care Operations as outlined in the NOTICE OF PRIVACY PRACTICES.