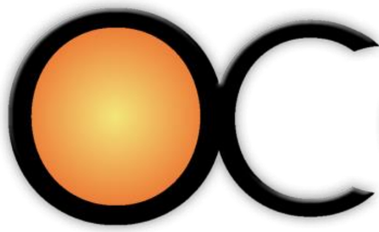


PATIENT INFORMATION

Name: ____ Date of Birth: _______________
First M.I. Last

E-mail: ___________________________________SSN: ____________________________ Male: ☐ Female: ☐

Address: ____ Apt #:_____ City/State: ________________ Zip: _________

Phone # Home: ________________________ Cell: _______________________ Work: ________________________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino Race: (Specify) ___________________________________

Preferred Language: ___________________________ Marital Status (Circle One): Married / Single/ Widowed/ Divorced

Occupation/Employer: ____________________________ Address: ____

Emergency Contact: _________________________ Relationship: ___________________ Phone #:________________

Primary Care Provider (Doctor):____ Phone #: ______________________

Pharmacy Name/Phone Number: ____

PARENT/GUARDIAN OR SPOUSE INFORMATION

Name: ____ Date of Birth: _______________
First M.I. Last

E-mail: ___________________________________SSN: ____________________________ Male: ☐ Female: ☐

Address: ____ Apt #:_____ City/State: ________________ Zip: _______

Phone # Home: ________________________ Cell: _______________________ Work: _______________________

INSURANCE INFORMATION Insurance: _____________________________________

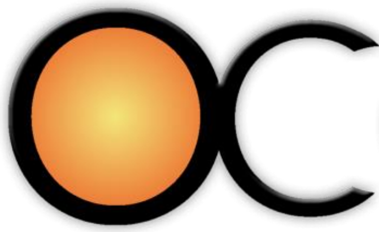
Please initial here: _________ if you do not have a secondary insurance.

SECONDARY INSURANCE INFORMATION Insurance: _____________________________________

I hereby authorize the above doctor/doctors to furnish to the insured's insurance company all information which said insurance may request concerning my present claim, including chart notes. I hereby assign to the doctor all money to which I am entitled for expenses relative to the services performed from time to time, but not to exceed my indebtedness to said doctor. It is understood that any money received from above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to said doctor for charges not covered by this assignment. If treatment is provided to a minor consent is authorized by legal guardian.

____ __________________

RESPONSIBLE PARTY SIGNATURE **DATE**



Medical Health History Form

Reason for visit: ____

List the medical problems that other doctors have diagnosed: ______________________________________

Surgeries/Hospitalizations: ____

Are you allergic to any medications? □ Yes □ No
Which ones? ____

Current Medications (include doses and nonprescription drugs): ______________________________________

____

Tobacco History: None_____ If quit, when? ______ cigarettes/packs per day ______ Years smoked? _______

Alcohol History: None _____ Average drink per day _____ per week______ per month______ per year_____

Any recreational drugs: ________________ Exercise: _________Type _______________Frequency_________

Family History:

	Age	Age at death	Medical problems/Cause of death
Father	_____	_____	___________________
Mother	_____	_____	___________________

OTHER PROBLEMS: **As you review the following list, please check any that apply to you recently**

□ Decreased hearing	□ Chest pain	□ Ringing in ears	□ Irregular pulse
□ Palpitations	□ Hives□ Swollen ankles	□ Hair loss	□ Leg pain when walking
□ Mole, changing	□ Tremors	□ Cold/numb feet	□ Headaches
□ Varicose veins/phlebitis	□ Loss of appetite	□ Rashes	□ Double/blurred vision
□ Difficulty swallowing	□ Eye pain	□ Heartburn	□ Weight changes
□ Foot pain	□ Gout	□ Testicular pain	□ Foot pain
□ Diverticulosis	□ Sinus trouble	□ Persistent vomiting	□ Numbness/tingling
□ Hernia	□ Arthritis	□ Back pain	□ Shortness of breath on exertion
□ Kidney stones	□ Pain/burning during urination	□ Bronchitis/chronic cough	□ Blood in urine
□ Shortness of breath lying flat	□ Jaundice/Hepatitis	□ Diarrhea	□ Bladder leakage
□ Constipation	□ Incontinence	□ Sleeping problems	□ Decreased force/flow
□ Hemorrhoid	□ Hoarseness	□ Hay fever/allergies	□ Sore throat

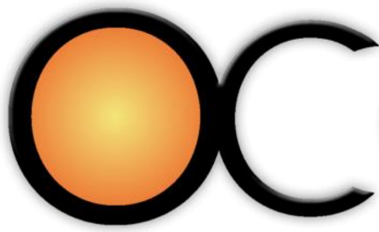
MALES:
□ Testicular pain
□ Penile pain/discharge

FEMALES:
□ Irregular menstrual cycles
□ Pain/bleeding during/after sex
□ Flushing/menopause
Date of last PAP_____□ Normal □ Abnormal

If any of the above boxes were checked, please explain: ______________________________________

Print Patient Name: ______________________________________ **DOB:** ____________

Provider Signature: ______________________________________ **Date:** ____________



PATIENT RESPONSIBILITY DISCLAMER

I, ____, understand that in order to cover this office visit, my medical insurance company **may** require a referral from my **Primary Care Provider**. I also understand that if **OC Urgent Care** has not received authorization for a referral from my Primary Care Provider, *or* in the case that my insurance policy does not cover my visit I will be financially responsible for any and all charges incurred, including labs, X-ray and any other services rendered.

I understand that there will be a fee for any returned checks.

Labs: We are contracted with **Quest/LabCorp/BioPath/CMB/Primex** you may receive a separate statement from them for any laboratory testing performed at our clinic.

_______ Initial of Patient or Parent/Guardian

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I have been given the opportunity to read and understand OC Urgent Care's Policies of Privacy Practices.

_______ Initial of Patient or Parent/Guardian

ACKNOWLEDGEMENT OF PRESCRIPTION POLICIES

I have been given the opportunity to read and understand OC Urgent Care's Prescription Refill Policy.

_______ Initial of Patient or Parent/Guardian

____ _______________

RESPONSIBLE PARTY SIGNATURE **DATE**

OUR POLICIES FOR PRESCRIPTION REFILLS

1) Deal directly with your pharmacy for all non narcotic medication refills. They will fax a request to our Providers which they will sign and fax back. (There is a 72 hour turnaround time for refills)

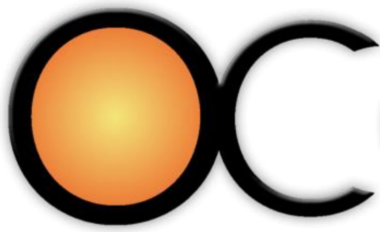
2) All narcotic pain relief medication, sleep aids, anti-anxiety medication and mood elevating drugs are regulated by state law. **They must be refilled by appointment during regular office hours only.**

3) We will not honor refill requests for **lost, stolen or misused medication.**

I have read and understand the prescription refill policies provided by OC Urgent Care. I agree to abide by these policies and should I have questions at any time I may ask for clarification.

____ _______________

RESPONSIBLE PARTY SIGNATURE **DATE**



NOTICE OF INFORMATION PRACTICES

This notice describes how medical information about you may be used, disclosed and how you can get access to this information. Please read it carefully.

Each time you visit a hospital, physician, or healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, explanation, test results, diagnosis, treatment, and plan for future care. Also known as your medical record and serves as a:

- Basis of planning your care and treatment
- Means of communication among the health professionals participating in your care.
- Legal document describing the care you received
- A source of information for public health officials charged with improving the health of the nation.
- A tool with which we can assess and continually work on to improve the care we deliver and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps to insure its accuracy; make informed decisions when authorizing disclosure to others: and better understand who, what, when, where and why others may access you health information.

Understanding Your Health Information Rights

Although your health record is the physical property of the healthcare provider, the information belongs to you. You have the right to:

- Request a restriction of certain uses and disclosure of your information.
- Obtain a paper copy of the notice of information practices upon request.
- Inspect and obtain a copy of your health record.
- Request to amend your health record.
- Obtain an accounting of disclosures of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

We are required to:

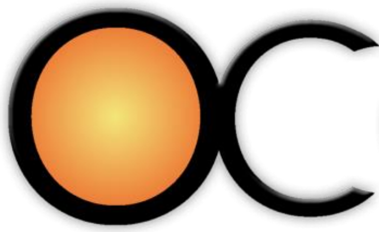
- Maintain privacy of your health information.
- Provide you with a notice as to our legal duties & privacy practices with respect to your information.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction on disclosure or amendment to your record.
- Accommodate reasonable requests you may have to communicate health information by alternative means or locations

We reserve the right to change our practices and to make the changes effective for all protected health information we maintain. A current Notice of Information Practices will be posted at our office.

If you have questions and would like additional information, you may contact out Clinic Administrator at 26781 Portola Pkwy, Ste. 4E, Foothill Ranch, CA 92610. If you believe your privacy rights have been violated, you may file a complaint with the Clinic Administrator or with the Secretary of Health and Human Services. We will not retaliate if you file a complaint.

Examples of Disclosure for Treatment, Payment and Health Operations

We will use & disclose your health information for treatment. We may disclose medical information about you to other providers : specialists, hospitals, home-health agencies, nursing homes, P.T., etc.



(IE: if you are referred to a specialist to treatment a broken bone, the specialist would need to know that your diabetic, since diabetes may slows healing process.)

We will use & disclose your health information for payment. (IE: a bill may be sent to you/ a third-party payer with information that may identify you, your diagnosis, procedures, & supplies. Along with any additional information to substantiate the medical necessity of the care delivered and that the care for which the claim was submitted was actually delivered. Further, we may disclose health information to the extent necessary to comply with the workers compensation or other similar programs established by law. We will also honor attorney requests for medical records that you have authorized by your signature.

We will use your health information for regular health operations. (IE: members of our quality improvement team may use the information in your health record to assess the care and outcomes if your case and others like it.) The information will then be used to continually improve the quality & effectiveness of the healthcare and services we provide.

Business Associates: There are some services provided in our organization through contracts with business associates such as a transcription service. When these services are contracted, we may disclose you health information to our business associate so that they can perform the job we've asked them to do. However, to protect your health information we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location and general condition.

Family communication: After careful judgment, we may disclose to a family member or other person you designate, health information relevant to that person's involvement in your care or payment related to your care.

Funeral directors & organ procurement organizations: We may disclose health information to funeral directors consistent with applicable law. We may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplement, produce and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Public Health: As required by law, we may disclose health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law Enforcement and Correctional Institution: We may disclose health information for law enforcement purposes as required by law. Should you be an inmate of a correctional institute, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, provided that we or our business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, the public.

EFFECTIVE DATE: July 21, 2010

____ ________________

RESPONSIBLE PARTY SIGNATURE **DATE**