Patient Registration

Family Choice URGENT CARE

Where did you hear about Family Choice Urgent Care?

_____ Friend _____ Letter _____ Mailer _____ Newspaper _____ Other _____ Internet

_____ Phone Book _____ Radio _____Relative _____Signage _____Work ____ Doctor Referral

Social Security Number: _____Date of Birth: _____

Patient Last Name: _____

Patient First Name: _____ Middle Initial: _____

Gender: ☐ Male ☐ Female Race: _____ Ethnicity (circle one): Hispanic or Latino
Not Hispanic or Latino
Preferred Language: _____ Patient Declines

Mailing Address: _____

City:_____State:_____Zip:_____

Home Telephone: _____ Mobile Telephone: _____

E-mail: _____

Patient Employer: _____ Marital Status: _____

Primary Care Physician: _____

Insurance Co-pay amount $: _____ Preferred Pharmacy: _____

Reason for today's visit: _____

Insurance Card Holder / Guarantor: _____
Last Name First Name M.I.

Guarantor's Street Address: _____

Guarantor's City:_____State:_____Zip:_____

Guarantor's Phone #: _____

Guarantor's Social Security Number:_____ Date of Birth:_____

Gender: ☐ Male ☐ Female Relationship to Patient: ☐ Parent ☐ Spouse

Guarantor's Employer Address _____

P:541-213-2133
F:541-640-8107
www.familychoiceuc.com

Patient Receipt of HIPAA Privacy Notice

Dear Patient,

Family Choice Urgent Care is committed to maintaining the integrity of your protected health information and complies with all applicable state and federal regulations.

The federal privacy regulations of the Heath Insurance Portability and Accountability Act (HIPAA) have taken effect April 14, 2003. In support of our policy of complying with all applicable regulations, Family Choice Urgent Care provides patients with the HIPAA Notice of Privacy Rights.

While not required in order to receive treatment at Family Choice Urgent Care, we are obligated under federal regulations to ask that you sign an acknowledgement of the HIPAA Privacy Notice being made available to you.

Thank you.

Receipt of HIPAA Privacy Notice I acknowledge receipt of the Notice of Privacy Rights with detailed information about how Family Choice Urgent Care may use and disclose my protected health information. I understand that Family Choice Urgent Care reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

_____

Printed Patient Name

_____Date: _____

Signature of Patient or Parent/Guardian

••••••••• Office Use Only: To be completed only when a patient declines to sign acknowledgement.
Check here if patient declined to sign acknowledgement

Staff Signature: _____Date: _____ Refusal to sign acknowledgement does not prevent the patient from continuing to be treated.

To be filed in patient's record

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CREDIT CARD/DEBIT CARD AUTHORIZATION

Family Choice Urgent Care submits claims to insurance carriers as a convenience to all our patients. At this time, we request authorization to balance bill a major credit card or debit card to cover amounts determined by your insurance to be your responsibility.

Upon receipt of an explanation of benefits from your insurance carrier any unpaid portion of your claim will be billed to your credit card or debit card. Should insurance pay in full, your account will not be charged.

All credit card/debit card information will remain absolutely confidential and securely stored by **First Data**. Family Choice Urgent Care will not store any banking account data.

I hereby authorize Family Choice Urgent Care to charge any and all outstanding balances, after insurance company reimbursement or denial, to my credit/debit card. I understand that I will not receive a statement if there is no balance due after processing my credit card for payment.

_____ _____

Cardholder's Authorization Signature **Date**

Family Choice
URGENT CARE

Consent Information

You expressly consent and agree that, in order to discuss or service your accounts(s) (the “Accounts “) or to collect amounts you may owe, [Family Choice Urgent Care], and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively, “We”) may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contact you by sending text messages, emails, using any e-mail address you provide to us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

_____

Patient Name

_____Today’s Date_____

Patient Signature

Family Choice
URGENT CARE

108 NW Sisemore, Suite 120
Bend, OR 99703-2869

P: 541-213-2133
F: 541-640-8107
E: info@familychoiceuc.com

NOTICE OF PRIVACY PRACTICES

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.

Understanding Your Medical Record / Health Information:

As your healthcare provider, we will maintain a record of your visit that contains your symptoms, reports of examinations and test results, diagnoses, treatments, correspondence with other providers and plans for future care or treatment.

Your Health Information Rights:

Your health record is the physical property of this practice; however the information it contains belongs to you. You have the following rights and we request that you notify the Privacy Officer of the practice of your requests for any of these actions:

a.) Request Restrictions: You have the right to request restrictions on the use of your information.

b.) Obtain a Paper Copy of this Notice: You have the right to receive a paper copy of this Notice.

c.) Inspect and Copy: You have the right to inspect and receive a copy of your health information. If you request a copy of your information, you may be charged a reasonable fee for photocopying, retrieval, labor, postage, and supplies used.

d.) Amend: You have the right to request that we amend your health information.

e.) Obtain an Accounting of Disclosures: You have the right to request an accounting of certain disclosures of information that have been made about you. The listing includes disclosures of your information for treatment, payment or healthcare purposes and is within a specified period of up to six years. The first listing of disclosures is provided as a complimentary service to you, bu you may be charged a reasonable fee for additional requests made within a twelve-month period.

f.) Request Communications of your Health Information: You have the right to request that you receive communications regarding your information in a certain manner or at a certain location.

g.) Revoke Your Authorization for Disclosure: You have the right to revoke an authorization for disclosure of information that was previously given.

Requirements & Responsibilities of Practice:

a.) Confidentiality: Maintain the privacy of your health information.

b.) Provide a Copy of this Notice: We will provide you with a copy of this notice of our legal duties and privacy regulations with respect to the information we collect and maintain about you.

c.) Abide by the Terms of this Notice.

d.) Unable to Restrict: We will notify you if we are unable to agree to a requested restriction of your information.

e.) Consider Alternative Means or at Alternative Locations: We will consider reasonable requests you may have to communicate health information by alternative means or at alternative locations.

Examples of Disclosure Information:

a.) Treatment

1.) We will use your health information for treatment purposes. As an example, information given to a nurse or physician will be recorded in your health record and used to determine the best treatment for you. Members of the healthcare team will document your treatment goals, actions taken and clinical observations.

2.) We will provide you other healthcare providers with copies of various reports that will help them to treat you for any subsequent conditions that may arise.

b.) Payment

1.) A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, your diagnosis, treatments, and supplies used.