PREMIER URGENT CARE

PATIENT INFORMATION

Name: _____ DOB: ____/____/_____

Age: _____ Sex: Male or Female **SSN#:** _____/_____/_____

Address_____City_____State_____Zip_____

Email Address: _____

Home Phone :(____) ____-_____Cell: (____) ____-_____Work: (___) ____-_____

(Complete if patient is under 18)

Guarantor: _____ Relation: _____ Phone: (___) ____-_____

Address_____City_____State_____Zip_____

Emergency Contact: _____ Relation: _____ Phone: (___) ____-_____

How did you hear about us? _____

Authorizations:

Treatment Release: *I hereby authorize the Physicians and Providers of Care to provide reasonable and proper medical care by current standards and within their scope of practice.*

Payments to Physicians: *I hereby authorize payments to be sent directly to the Physician. I also understand that my insurance is a contract between myself and my insurance company and that I am responsible at the time of service for any portion of my bill not covered by my plan. I understand that any outstanding patient balance over 90 days past due may be turned over to a collection agency and subjected to additional collection fees.*

Release of Information: *I hereby authorize release of information for treatment and payment purposes within federal HIPAA guidelines. I have reviewed the Notice of Privacy Practices given to me. A photocopy or facsimile of this page and signature below will be as valid as the original. I wish to authorize the following individual(s) access to my medical information:*

_____ _____

(name & relationship) *(name & relationship)*

I understand all of the above and hereby state that the information is correct to the best of my knowledge. My signature indicates that I have read the above and grant authorizations.

Signed_____Date:_____/_____/_____

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Please complete the insurance in the order in which it should be filed

Primary Insurance Name: _____

Insurance Coverage / Responsible Party: (Please fill out policy holder's information if filing insurance)

Name: _____ DOB: ____/____/_____ SSN#:_____/____/_____

Address_____City_____State_____Zip_____

Relation: _____ Phone: (____)-_____-_____

Secondary Insurance Name: _____

Insurance Coverage / Responsible Party: (Please fill out policy holder's information if filing insurance)

Name: _____ DOB: ____/____/_____ SSN#:_____/____/_____

Address_____City_____State_____Zip_____

Relation: _____ Phone: (____)-_____-_____

Tertiary Insurance Name : _____

Insurance Coverage / Responsible Party: (Please fill out policy holder's information if filing insurance)

Name: _____ DOB: ____/____/_____ SSN#:_____/____/_____

Address_____City_____State_____Zip_____

Relation: _____ Phone: (____)-_____-_____

I understand all of the above and hereby state that the information is correct to the best of my knowledge.

Signed_____Date:_____/_____/_____

PREMIER + URGENT CARE

PATIENT CONSENT FORM

Use of this form is optional and not required under the HIPAA privacy rule.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Premier + Urgent Care** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **Premier + Urgent Care** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Premier + Urgent Care** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **HIPAA Officer, 1616 S Mustang Rd. Yukon, OK 73099**

With this consent, **Premier + Urgent Care** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Premier + Urgent Care** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **Premier + Urgent Care** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Premier + Urgent Care** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Premier + Urgent Care** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Premier + Urgent Care** may decline to provide treatment to me.

Signed by:_____ _____ _____

Signature of Patient / Legal Guardian | Date | Relationship to Patient

_____ _____

Print Patient's Name | Print Name of Legal Guardian or Patient

Patient/guardian must sign a copy of this authorization form.