Hometown URGENT CARE & OCCUPATIONAL HEALTH

Patient Registration

Account #

Chart #

Please present your insurance card at the time of check-in.
Settlement of patient financial responsibility is expected at the time of service.

PATIENT INFORMATION

Last Name	**First Name**	**MI**
SSN	**DOB**	**Gender** ❒ M ❒ F
Street		
City	**State**	**Zip**
Home Phone	**Mobile Phone**	
Email	**Birthplace**	
Primary Care Provider	**Pharmacy:**	
I give consent to send a copy of my medical record to the PCP listed above ❒ Y ❒ N		
Preferred Language	**Race** ❒ American Indian or Alaska Native; ❒ Asian; ❒ Black or African American; ❒ Native Hawaiian or Pacific Islander; ❒ White	**Ethnicity** ❒ Hispanic or Latino ❒ Not Hispanic or Latino
Please explain the reason for your visit today		
Please list any medications you are taking ❒ None		
Please list any medication allergies ❒ None		

EMERGENCY CONTACT

Contact Name	**Relationship**	
Street		
City	**State**	**Zip**
Home Phone	**Mobile Phone**	
Best Form of Contact ❒ Home Phone; ❒ Mobile Phone; ❒ Work Phone; ❒ Email		
Best Time to Call	**Leave Message** ❒ Y ❒ N	

GUARANTOR (responsible party if under 18)

Name	
DOB	**SS#**
Address	
Home Phone	**Mobile Phone**

EMPLOYMENT

Employer			
Street			
City		**State**	**Zip**
Employer Phone	**Employer Fax**	**Employee Phone**	
Occupation		**Title**	

HOW DID YOU HEAR ABOUT US?

PARTNER/PARENT EMPLOYMENT

❒ Partner ❒ Parent	**Name**
Phone	

PRIMARY INSURANCE INFORMATION	SECONDARY INSURANCE
Is the patient covered by insurance? ❒ Y ❒ N	
Insurance Co	**Insurance Co**
Plan Name	**Plan Name**
ID#	**ID#**
Group #	**Group #**
Insured Name	**Insured Name**
Insured SS#	**Insured SS#**
Relation to Patient	**Relation to Patient**
Street	**Street**
City	**City**
State	**State**
Zip	**Zip**
Home Phone	**Home Phone**
Mobile Phone	**Mobile Phone**
DOB	**DOB**
Employer	**Employer**
Copay Amount	**Copay Amount**

AUTHORIZATION AND RELEASE

By signing this consent form I acknowledge that I have read, understand, voluntarily consent to and authorize the following:

Authorization of Treatment:

I authorize the administration and cost of all medical and surgical procedures, x-ray, and medication for myself and my dependents.

Guarantee of Payment:

_____ **(Initial) Self Pay**: I elect to pay for all services rendered in full today. I understand that my insurance will NOT be billed by Hometown Urgent Care.
_____ **(Initial) Insurance – Assignment of Benefits:** I authorize payment directly to Hometown Urgent Care for all benefits otherwise payable to me. I understand that I am financially responsible for all charges not covered by insurance. I authorize Hometown Urgent Care to submit claims to my insurance carrier as well as medical records required to evaluate these claims for payment. I understand that if my employer is responsible for all or part of this claim, they will receive the necessary medical information required to evaluate these claims for payment.

Receipt of Privacy Practices:

By signing this consent form I acknowledge that a copy of the Notice of Privacy Practices of Hometown Urgent Care has been offered/is available to me upon request.

Patient Signature _____ Date _____

Responsible Party _____ Date _____

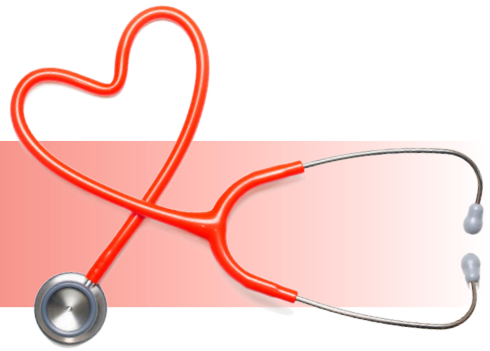
Release of Medical Records:

I authorize Hometown Urgent Care to release verbally, electronically and/or in writing confidential medical information obtained during the course of my examination and/or treatment to any person or entity including my insurance carrier, employer (if treatment is related to employment), and/or other healthcare provider(s) for purposes of treatment, payment of charges, quality assurance and utilization review. I understand that should I choose not to release my medical records to a specific entity and/or person(s) I must specifically state so in writing for inclusion in my medical record.

Patient Signature _____ Date _____

Hometown
URGENT CARE
& OCCUPATIONAL HEALTH

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION



What is This Notice For?

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

What Do We Do To Keep Your Health Information Private?

Keeping your health information private is one of our most important responsibilities. We are committed to protecting your health information and following all laws regarding the use of your health information. You have the right to discuss your concerns about how your health information is shared. The law under the Health Insurance Portability and Accountability Act (HIPAA) says:

1. We must keep your health information from others who do not need to know it
2. We must make this Notice available to you, and may only use and share your health information as explained in this Notice

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Who May Use And See My Health Information?

I understand this information can and will be used to:

1. Conduct, plan and direct my treatment and follow- up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
2. Obtain payment from third-party payers
3. Conduct normal healthcare operations such as quality assessments and physician certifications
4. For judicial & administrative proceedings according to specific requirements
5. For health-related research that meets applicable legal requirements

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Could My Health Information Be Used or Released Without My Authorization?

We follow laws that tell us when we have to share health information, even if you do not sign an authorization form. We will use or release your health information:

1. For public health reasons, including to prevent or control disease or injury; or report births or deaths, suspected abuse or neglect, reactions to medications or problems with certain health-related products.
2. To prevent serious threats to your health or safety or that of another person or the public.
3. To help health oversight agencies monitor the health care system, government programs, and compliance with civil rights laws, including for audits, investigations, inspections, or licensing purposes.
4. If a court orders us to or if we receive a subpoena and receive certain assurances from the person seeking the information.
5. To law enforcement officials, if we receive a proper request and the request meets all other legal requirements.
6. To coroners, medical examiners or funeral directors, in order to help identify a deceased person, determine the cause of death, or perform other legally authorized duties.
7. To organ procurement organizations, if you are an organ donor or as legally required.
8. For health-related research that meets applicable legal requirements.
9. To military authorities, if you were or are a member of the armed forces and the request is made by appropriate military command authorities.
10. To authorized federal officials for national security purposes.
11. To Workers Compensation for work-related injuries.
12. To other government benefit programs in order to coordinate or improve administration and management of the programs.
13. To family or others involved in your treatment or financial affairs, if you have indicated that we can do so or if we can reasonably infer that you do not object.

Hometown URGENT CARE & OCCUPATIONAL HEALTH

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION (CONT.)

What Other Rights Do I have With Regards To My Health Information

If you think some of your health information is wrong, you may ask that corrected or new information be added by making a request in writing to the HIPAA Compliance Office, Hometown Urgent Care, 1105 Schrock Road, Suite 200, Columbus, Ohio 43229. You must state why you think the correction or new information is necessary. We do not have to make the requested amendment. If we do, you may ask that the corrected or new information be sent to others who have received your health information from us.

You can get a list of where we shared your health information for the last 6 years, beginning on April 14, 2003, unless it was shared for treatment, payment, or healthcare operations. If you ask for more than one list a year, you may be charged for the cost of providing the list.

You may request that we communicate with you in a certain way or at a certain location. For example, you can ask that we only contact you by mail or phone, or at an address or phone number other than at your home.

If you ask for a paper copy of this Notice, we must give you one. We reserve the right to change this Notice, and to apply the new practices to all of your health information, including information we received before the Notice was changed. You may request a current copy.

Complaints or Questions?

If you have questions or feel your privacy rights have been violated, you can ask questions or complain by writing to the HIPAA Compliance Office, Hometown Urgent Care, 1105 Schrock Road, Suite 200, Columbus, Ohio 43229 (614) 505-7601.

Release of Information

You will be asked to sign a separate document, the Patient Registration Form, acknowledging a copy of our Privacy Policy has been offered or received; and we are allowed to share your health information for treatment, payment and/or business operations.

Effective 1/1/2014