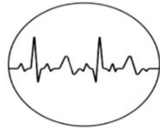


PRIORITY
Family & Urgent Care

Patient Full Name____

Preferred Name (if different from first)______________________ **Date of Birth** ______________

Mailing Address ____

Social Security # ________-________-________ Sex: (M) (F) **Marital Status:** (M) (S) (W) (D) Age ________

Email address ____

Primary Phone ______________________ **Secondary Phone** ______________________

Emergency Contact ____

Relationship ______________________ **Telephone** ______________________

SEXUAL ORIENTATION:

Assigned sex at birth ____M ____F **Gender Identity** _____M _____ F _____ Choose not to disclose

Sexual Orientation _____ Straight _____ Homosexual _____ Bisexual _______ Choose not to disclose

PATIENT EMPLOYEMENT:

Name of Employment ____

Address ______________________ **Phone Number** ______________________

RESPONSIBLE PARTY: (if other than patient)

Full Name ____

Relation to Patient ____

Mailing Address ____

Social Security # ________-________-________ **Date of Birth** ______________________

Home Phone ______________________ **Cell Phone** ______________________

PATIENT INSURANCE:

Insured's information: In order to file your insurance correctly, please make sure the check-in receptionist has a copy of your current insurance card(s) at each visit. It is the patient's responsibility to make sure we have the correct insurance on file at the time of service.

Primary Insurance Company Name:

Primary Policy Holder's Name: **Date of Birth:**

Primary Insured's SS#: **Policy Holder ID#:**

Secondary Insurance Company Name:

Secondary Policy Holder's Name:

Secondary Insured's SS# **Date of Birth:**

Signature of Patient/ Responsible Party ______________________ **Date** ______________

PRIORITY
Family & Urgent Care

Today's Date ________________________

First Name ____________________________ **Last Name** ____________________________ **Date of Birth** _____________

Pharmacy ____ **Location** ____

Smoking Status: Former Smoker/ Non Smoker **Alcohol** *(circle)* Occasional Moderate Daily

Medical Allergies: *(Please list the medicine and type of reaction)*

____ ____

____ ____

____ ____

Personal Medical History:

____ ____

____ ____

____ ____

Family Medical History:

____ ____

____ ____

____ ____

Medicine *(Please list all current medications and dosage or attach a list)*

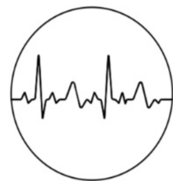
____ ____

____ ____

____ ____

List the names and relationships of those you authorize us to discuss your personal health information

Name	Relationship	Phone Number
_________________________	_________________________	_________________________
_________________________	_________________________	_________________________



PRIORITY
Family & Urgent Care

Consent for Treatment & Release of Health Information

Name of Patient: ____ Date: _______________________

1. CONSENT FOR TREATMENT: I request and voluntarily consent to the usual medical services as a patient at **Priority Family & Urgent Care, LLC** (hereinafter referred to as “the clinic”), as well as the diagnostic laboratory (test of the blood or other bodily fluids) whether it be in house labs or send out labs, and x-ray procedures and medical treatment as well as any other treatment deemed necessary by my provider and his or her assistants. The clinic is authorized to retain, preserve, and use for scientific or teaching purposes or dispose of at its convenience, any specimens or tissue removed from my body during treatment.

2. MEDICAL CARE: During treatment at the clinic, I (the patient), will be under the professional care of a physician. I understand that no guarantees have been made as a result of examination or treatment while in the clinic.

3. COMPLIANCE WITH RULES & REGULATIONS: In consideration of treatment, I agree to abide by the rules of the clinic, including no smoking.

4. PERSONAL VALUABLES: I agree that the clinic will not be liable for the loss of or the damage to any of my personal property that I may bring to the clinic.

5. RELEASE & RESPONSIBILTY: I hereby agree, acknowledge, and understand that the clinic is not responsible for and agree that if I should leave the clinic without the consent of my provider (against medical advice), I hereby relieve my provider and the clinic of all responsibility of such action.

6. CONSENT TO DESTROY X-RAY & RADIOGRAPHOC DATA: I hereby authorize the clinic to retire or destroy my x-ray images (film and/or digital), and any other radiographic date, for (4) years after generation, if a proper report is in the medical record.

7. ASSIGNMENT OF BENEFITS: As the patient or patient’s representative, I make the following assignment of benefits. MEDICARE/ MEDICAID: I hereby request that payment of authorized Medicare and/ or Medicaid benefits to or on my behalf for services rendered in or by the clinic, shall be made to the clinic, and I specifically assign such benefits to the clinic. I hereby certify that all information I provide, in connection with applying for benefits under Title XVIII of the Social Security Act, is true and correct, and complete in all respects. I understand that payments for services deemed not medically necessary by Medicare/ Medicaid are not authorized under the Medicare/ Medicaid program, and I may be responsible for the incurred charge(s), unless other third-party coverage is available.

   INSURANCE: I hereby assign to the clinic all rights, benefits, and interest under any insurance policy, health plan, workers' compensation, or other third-party payer for treatment received at or by the clinic. I hereby authorize payment of workers’ compensation coverage directly to the clinic for expenses incurred at the clinic. I hereby authorize payment directly to the clinic of all third-party liability insurance coverage, third party payer, health plan, and individual liability. Insurance coverage for medical expenses incurred as a result od any accident, injury, or illness for which I

received treatment at the clinic. I understand that I am responsible for ensuring that all claims are submitted to my insurance company, the submission of my insurance claims by the clinic is only a courtesy, and there is no guarantee that all claims are properly submitted.

8. FINANCIAL RESPONSIBILTY: I understand that I am financially responsible to the clinic for all charges not paid by insurance. I also understand and agree that all deductibles, co-insurance, non-covered charges, and other items not paid by insurance, health plan, or other third-party payer are due and payable upon services rendered based on the best estimates available as determined by the clinic. Charges remaining on this account which are not paid by insurance health plan, or other third-party payer, are payable upon demand. Outside lab services will be billed directly to you by the lab company. I also agree that if this account is assigned to a collection agency or attorney for collection or suit, all collection fees, attorney fees, cost, and other expenses will be paid by me. I also understand, agree and authorized the clinic to verify employment status for the purpose of processing my clinic bill for payment.

9. COMMUNICATION: I authorized all clinical providers who have provided care or interpreted my test, along with any billing services and their collection agency or attorney who may work on their behalf, to contact me using pre-recorded messages, artificial voice messages, automatic telephone dialing devices. Services, or other computer-assisted technology, and/ or by email, text messaging, or any other form of communication.

10. CONSENT FOR THE RELEASE OF HEALTH INFORMATION FOR BILLING & PAYMENT PURPOSES: I hereby consent to the release of my health information (medical records, medical results and all other health information) by the clinic or any provider involved in my care for the purposes reimbursement; and certification to any insurance company, third party payer, health plan, or government agency which is necessary for the billing and payment of my account.

11. NOTICE OF PRIVACY PRACTICES: Priority Family & Urgent Care, LLC uses E-Clinical to electronically exchange date regarding prescriptions and related information between my providers and pharmacies. The information sent between these systems may include details of prescription drugs I am currently taking and/ or have taken in the past. This information will be utilized by Priority Family & Urgent Care, LLC. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/ or confidential HIV related information by E- Clinical to Priority Family & Urgent Cere, LLC. By signing below, I acknowledge that I have been informed of and. Or received the clinic's Notice of Privacy Practices.

12. DISCOULSURE OF PERSONAL HEALTH INFORAMTION: Priority Family & Urgent Cere, LLC will not, without your authorization, discuss your personal health information with anyone except those allowed under the Federal and State Law or those listed below.

Acknowledge and agreed to by:

____

Print Patients Name & Date of Birth

____ ______________________________

Signature of Patient/ Personal Representative Date