URGENTCARE OF FAIRHOPE

Identification

Legal last name: _____ Legal first name: _____

First name used: _____ Middle Initial: _____

DOB: _____ Legal sex: M / F Gender Identity: _____

Marital Status: _____Race: African American Asian White Ethnicity: _____

Contact Info

Mailing Address: _____

City: _____ State: _____ Zip: _____

County: _____

Home phone: _____ Cell phone: _____

Which do you prefer to be reached at, home or cell? _____

Consent to text ○ Yes ○ No Consent to call ○ Yes ○ No

The patient Portal is your online access to lab results, visit notes, direct communication with your healthcare provider, and bill pay. By providing your email, you are consenting to our patient portal.

Patient email for portal: _____

How did you hear about us? _____

Insurance Policy Holder's Name: _____ Policy Holder's DOB:_____

Emergency Contact

Name: _____ Relationship: _____

Home/Cell phone: _____

Guarantor (to whom billing statements should be sent)

Patient's relationship to guarantor: _____

Last name: _____ First name: _____

Mailing Address: _____

City/State/Zip Code: _____

8096 Twin Beech Rd. Suite 150
Fairhope, AL 36532

Please Read: Urgent Care of Fairhope does not treat the following: Refills of narcotic or controlled substances, sexual dysfunction, STD screening without symptoms, or psychiatric disorders. If you need a list of providers for one of these services, please speak to one of our staff.

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. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual. For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you. For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses. technicians. medical students, or other personnel who are involved in taking care of you at the Practice or the hospital. For example, we may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy or other persons that arc part of your care. For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students. and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts. WHO WILL FOLLOW THIS NOTICE. This notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you. as well as all employees, staff and other Practice personnel. POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the Practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Practice, whether made by Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; public health risks; and worker's compensation. NOTICE OF INDIVIDUAL RIGHTS You have the following rights regarding medical information we maintain about you: Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances. Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment. Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer. Right to Request Removal from Fund raising Communications. You have the right to opt out of receiving fundraising communications from the Practice. Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full. Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted. Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the Practice's waiting room. COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact Lacey E. Norrell, Privacy Officer, 251-450-3700 3280 Dauphin Street Bldg A, Mobile, AL 36606. All complaints must be submitted in writing. You will not be penalized for filing a complaint. OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.
https://secure.clearwaveinc.com/ProviderPortal/encounters/2650/visit/290322021/consentf... 3/18/2022 ACKNOWLEDGMENT OF RECEIPT OF Health Insurance Portability and Accountability Act of 1996 (HIPAA) PRIVACY PRACTICES AND CONSENT Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. It also provides information about your rights as a patient of our practice and whom you may contact at our office to ask questions about our privacy practices. By signing this form, I hereby acknowledge that I have had the opportunity to read the Notice of Privacy Practices of Urgent Care of Fairhope and understand that in compliance with that notice, Urgent Care of Fairhope is allowed to use or disclose my individually identifiable health information for purposes of treatment, payment, and health care operations. I further understand that the Notice of Privacy Practices provides a more complete explanation of the use or disclosure of my individually identifiable health information.

I have read a copy of Urgent Care of Fairhope 's HIPAA Notice of Privacy Practices and understand the information it contains.

Patient/Guardian Signature: _____ Date: _____

Name of Guardian: _____ Relationship to Patient: _____

CONSENT TO TREATMENT

I authorize Urgent Care of Fairhope to perform medical treatment. I consent to Urgent Care of Fairhope, use and disclosure of all individually identifiable personal, health, financial and demographic information (known as Protected Health Information PHI) for the purpose of:

- Providing medical treatment
- Obtaining payment and reimbursement
- Obtaining authorization from my insurance
- Requesting healthcare services from other providers
- Cooperating with other providers in my medical treatment
- Fulfilling requests for information when specifically authorized by me
- In addition, doing all other things directly related to providing healthcare to me

Patient/Guardian Signature: _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Urgent Care of Fairhope LLC to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated during examination or treatment.

This order will remain in effect until it is revoked by me in writing.

Patient/Guardian Signature: _____ Date: _____

Health Insurance Disclaimer

NETWORK STATUS WITH A HEALTH INSURANCE PAYER DOES NOT GUARANTEE PAYMENT BY YOUR INSURANCE PLAN. IT IS THE PATIENT'S REPONSIBILITY TO KNOW WHO THEIR PLAN ALLOWS THEM TO SEE, IF REFERRALS ARE REQUIRED, AND WHO THEIR SPECIFIC PLAN DEEMS IN NETWORK.

Patient/Guardian Signature: _____ Date: _____

8096 Twin Beech Rd. Suite 150
Fairhope, AL 36532

URGENTCARE OF FAIRHOPE

Medical Information Release Form

IS THERE ANYONE (FAMILY, FRIEND, DR/MEDICAL OFFICE) THAT YOU WOULD LIKE TO BE ALLOWED ACCESS TO YOUR MEDICAL RECORD? List them below!

By completing this form, I authorize the release of my complete medical record and confidential medical information via fax, phone or mail to the person/physician/facility listed below. This Release of Information will remain in effect until terminated by me in writing.

Patient Name: _____ Date of Birth: _____/ ____/_____

OR check box if ☐ My confidential medical information is not to be released to anyone.

Name of person or facility: _____

Relationship to Person/Facility: _____

Address: _____

City/State/Zip: _____

Phone/Fax Number: _____

Name of person or facility: _____

Relationship to Person/Facility: _____

Address: _____

City/State/Zip: _____

Phone/Fax Number: _____

Name of person or facility: _____

Relationship to Person/Facility: _____

Address: _____

City/State/Zip: _____

Phone/Fax Number: _____

Patient/Guardian Signature: _____

Date: ___/ _____ /_____ You're all done!! Please return the completed forms to our receptionists.

8096 Twin Beech Rd. Suite 150
Fairhope, AL 36532