MinuteMed
Walk-In Medical Clinic

NEW PATIENT INFORMATION FORM

Patient Information

Name: _____ Sex: M / F
Last First MI SUFFIX

Date of Birth: ___/_____/_____ SS#: _____-_____-_____ Phone: (___) _____-_____

Address: _____ _____ _____ _____
City State Zip

Email_____ Employer: _____

Emergency Contact: _____ (_____) _____-_____ Relationship: _____
Name Number

Do you have insurance? ____ Yes ____ No If Yes, what insurance carrier? _____

If you have insurance, please provide card to receptionist to copy/scan.

CONSENT TO USE AND DISCLOSE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS.

- I consent to the participation of professional healthcare students in my care. Nursing students participate in patient care as a necessary part of the patient care team under supervision of licensed personnel. At all times, my personal wishes control the extent of my participation in the educational programs. At any time, I may withdraw my consent to having students care for me.
- I consent to the photographing or video recording of the procedure(s), treatment(s), to be performed, including appropriate portions of my body, for medical, scientific, or educational purposes, provided my identity is not revealed by pictures or by the descriptive text accompanying them.
- I hereby acknowledge that I have the right to request a copy of a written notice of my privacy rights and,
- I consent to MinuteMed Walk-In Clinic using and disclosing my protected health information to carry out treatment, payment, or health care operations.
- I understand I have the right to request and review a copy of a *Notice or Privacy Practices*, which provides a more complete description of how to protect my health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent.
- I understand that MinuteMed Walk-In Clinic reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by written request.
- I understand that I have the right to restrict how MinuteMed Walk-In Clinic uses or discloses my protected health information to carry out treatment, and payment for provided services.
- I request the following restrictions to how my health information is used or disclosed:_____

Signature: _____ Date: _____

I consent to have my medical records released to my primary care physician or the person listed as my emergency contact.
Initials: _____

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MinuteMed Walk-In Clinic Scope of Treatment

I understand that MinuteMed is a Walk-In clinic and not an EMERGENCY ROOM. I also understand that MinuteMed cannot treat life threatening or emergent conditions. I am also aware that if I am treated here at MinuteMed, I will follow up with my primary care physician or the local emergency room if my condition does not improve or if it worsens.

Signature: _____ **Date:** _____

I acknowledge that MinuteMed Walk-In Medical clinic does not treat for chronic pain or major psychiatric illness. We feel that these conditions are better treated by a specialist.

Initials: _____

ATTENTION ALL PATIENTS

Please read and initial.

MinuteMed **DOES NOT** accept **Medicare** or **Medicaid**, either as primary or secondary insurance.

Initials_____

I acknowledge that copays and contract charges based on my insurance carrier is due at the time of service. Payments are only estimated, according to benefits provided by my insurance company. I understand that I may or may not receive a bill depending on how the insurance processes the claim.

Initials_____

PATIENT'S RIGHTS AND RESPONSIBILITIES

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.

- A patient has the right to be given by the health care provider information concerning planned course of treatment, alternatives, risk, and prognosis.
- A patient has the right to refuse treatment, except as otherwise provided by law.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, must notify the health care provider.

I understand and agree with the above patient rights and responsibilities.

Signature: _____ **Date:** _____

ASSIGNMENT AND RELEASE

- I assign to MinuteMed Walk-In Clinic my insurance benefits. Otherwise, services rendered will be payable to me.
- I understand that I am financially responsible for all charges whether or not paid by insurance.
- I hereby authorize MinuteMed Walk-In Clinic to release all information necessary to secure the payment benefit.
- I authorize the use of this signature on all insurance submissions.
- I understand that if, for any reason, this account is placed with a collection agency, any collection fee will be my responsibility.
- I also authorize this office to provide the necessary medical treatment to improve my health.

Signature: _____ **Date:** _____