Prestige Pediatric & Family Urgent Care Clinic

New Patient Information and Consent

What is the reason for your visit today?

Patient Information

Name (First, Middle, Last)		Birth Date	Age	Social Security #	Birth Gender ☐ M ☐ F
Mailing Address	Apt #	City, State ZIP			
Email Address		Primary Phone ☐ Home ☐ Cell	Okay to leave message? ☐ Yes ☐ No		
Employer (or parent/guardian employer if patient is a minor)		Work Phone			
Primary Care Provider (where you go for your routine medical care)		☐ None ☐ Doctors Care is my primary care provider			
Preferred Language		Race ☐ Black or African American ☐ Asian ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ American Indian/Alaska Native ☐ Prefer not to answer			
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino					

Emergency Contact

Contact Name	Phone Number	Relationship to Patient

Guarantor/Responsible Party (person responsible for payment)

Legal Name of Responsible Party (First, Middle, Last)	Social Security #	Date of Birth

Preferred Pharmacy

Pharmacy Name	Pharmacy Location

Medical Insurance (please present your ID and insurance card to the receptionist)

PRIMARY Insurance Company Name	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent
Insurance Company Address (usually on back of insurance card)		Phone

SECONDARY Insurance Company Name	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent
Insurance Company Address (usually on back of insurance card)		Phone

New Patient Information and Consent

Workers' Compensation

Is your visit today for a workers' compensation claim? ☐ Yes ☐ No

Worker's Compensation Billing Address

I hereby authorize CSMC Inc. to speak to a rehabilitation specialist, my employer, my insurance carrier or other professionals involved in my care of rehabilitation, regarding my medical records and the treatment I have received or will receive.

X _____ _____

Patient or Authorized Person's Signature Date

Accident/Injury Information

Not Applicable ☐

Where did the injury occur? (example: park) _____

Were you struck by an object? ☐ Yes ☐ No If Yes, what type of object? _____

Where did you fall? (example: kitchen, bathroom, garage) _____

Where did you fall from? (example: ladder, roof, steps) _____

If you were in a motor vehicle accident, were you the driver or passenger? _____

Authorization for Release of Information

May we leave testing results or referral info in email or voicemail? ☐ Yes ☐ No

Who may receive information on your behalf regarding testing or referrals? Name: _____

Patient Consent for Treatment

1. I voluntarily consent to any and all health care treatment and diagnostic procedures provided by CSMC Inc. and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at .
2. I agree to be contacted via email or SMS with information related to my visit, like: a patient portal invitation, post-visit satisfaction survey, appointment or checkup reminders, health tips, or new services that relate to me or my family.
3. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the CSMC Inc. Notice of Privacy Practices.
4. I authorize payment of medical benefits to CSMC Inc. physicians or their designee for services rendered.
5. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

I have received a copy of the Notice of Privacy Practice and Financial Policy Notice. ☐ Yes ☐ No Initial _____

X _____ _____

Patient or Authorized Person's Signature Date

Prestige Pediatric & Family Urgent Care Clinic

Patient Medical History

Today's Date: _____

Patient Name: _____ Date of Birth: _____

PATIENT HISTORY

No Past Conditions ☐

CHECK ANY CONDITIONS YOU ARE CURRENTLY BEING TREATED FOR OR HAVE HAD IN THE PAST:

☐ Heart disease	☐ Anemia or other blood disease	☐ Severe headaches	☐ Neck pain
☐ High blood pressure	☐ Thyroid disease	☐ Seizures	☐ Back pain
☐ High cholesterol	☐ Stomach disease	☐ Stroke	☐ Sleep apnea
☐ Lung disease	☐ Kidney, bladder or prostate disease	☐ Blood clots	☐ _____
☐ Diabetes	☐ Cancer (past or present)	☐ Depression	

ALLERGIES (include medication, food, latex and environmental allergies)

No Known Allergies ☐

Allergy to:	1. _____	2. _____	3. _____
Severity:	☐ Mild ☐ Moderate ☐ Severe	☐ Mild ☐ Moderate ☐ Severe	☐ Mild ☐ Moderate ☐ Severe
Reaction:	_____	_____	_____

CURRENT MEDICATION (include non-prescription products)

No Current Medication ☐

1. _____	3. _____	5. _____	7. _____
2. _____	4. _____	6. _____	8. _____

PREFERRED PHARMACY

Pharmacy Name: _____ Location: _____

PROCEDURES/SURGERIES

Approximate Date	Surgery	Approximate Date	Surgery
Approximate Date	Surgery	Approximate Date	Surgery

PREVENTATIVE SCREENING

Have you had a colonoscopy?..... ☐ Yes ☐ No If yes, date: _____

Have you had a mammogram?..... ☐ Yes ☐ No If yes, date: _____

WOMEN'S HEALTH

When was your last menstrual cycle?..... Date: _____

Patient Medical History — Page 2 Today's Date: _____

Patient Name: _____ Date of Birth: _____

FAMILY HISTORY

Mother:	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Father:	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Sister:	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Brother:	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Grandmother (M):	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Grandmother (P):	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Grandfather (M):	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Grandfather (P):	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A

OTHER HEALTH ISSUES

Do you drink alcohol?	☐ Yes	☐ No	☐ Beer ☐ Wine ☐ Liquor	_____ per week	
Do you smoke cigarettes?	☐ Yes	☐ No	If yes, _____ per day,	_____ years of use	
Do you use other forms of tobacco?	☐ Yes	☐ No	☐ Pipe ☐ Cigar ☐ Snuff/Chew		
Do you use an e-cigarette?	☐ Yes	☐ No	If yes, _____ per day,	_____ years of use	
Marijuana / recreational drug use?	☐ Yes	☐ No	If yes, _____ per day,	_____ years of use	

IMMUNIZATIONS

Influenza (18 years of age and older)?	☐ Yes	☐ No	If yes, date: _____
Pneumoccal (65 years of age and older)?	☐ Yes	☐ No	If yes, date: _____
Tetanus?	☐ Yes	☐ No	If yes, date: _____

Prestige Pediatric & Family Urgent Care Clinic

Authorization for Release of Health Information

Expires upon one time release of information.

Patient Name: _____ DOB: _____

Address: _____

City, State ZIP: _____ Phone: _____

Email: _____

I authorize CSMC Inc. **and its properties to release my health information to:**

☐ Self ☐ Other (specify below):

Name: _____

Company/Organization: _____

Address: _____

City, State ZIP: _____ Phone: _____

Email: _____ FAX: _____

Disclosed health information to include:

☐ Imaging ☐ Provider Notes ☐ Lab Reports

☐ Other: _____

Patient Information

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.*

I understand that I have the right to revoke this authorization by sending a written notification to CSMC Inc. I also understand that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification.

Written notification may be sent to customerservice@prestigeurgent.com

Expiration Date/Event: _____

X _____ _____

Signature of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority (attach documentation as necessary)

Prestige Pediatric & Family Urgent Care Clinic
Financial Policy and Disclosure

The Financial Policy and Disclosure is to help us provide the most efficient and reasonable health care services. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements for payment for services provided to patients.

Patients are responsible for the payment of all services provided by Doctors Care and UCI Medical Affiliates.

Self-Pay Policy
- If you are a self pay patient, you will be required to pay for the office visit before services are rendered.
- In addition, any remaining balance on your account will be collected at discharge.

Insurance Policy
- If you are an insurance patient, it is our policy to file for insurance as a courtesy to you, if we have accurate and complete insurance information.
- If a service is provided that is not covered by your insurance company, you will be the responsible party at the time of service. Non-covered services and supplies may include medical supplies, durable medical equipment, medications, x-ray supplies, and labs you receive at any Doctors Care facility.
- If we have not received a payment from your insurance company within the contracted time frame specified by your insurance company's contract with Doctors Care, you will be responsible for the balance due.
- Deductibles, co-payments, and coinsurance will be collected before services are rendered.
- In special cases, we may need your help in contacting your insurance company for the payment of your services.

Workers Compensation Policy
- If you are a workers' compensation patient, it is our policy to bill your employer or the workers' compensation carrier for services rendered.
- If you are covered under workers' compensation, we will accept the payments by the workers' compensation carrier as per contracted rates based on the mandated SC state fee schedule.
- If payment is denied from your workers' compensation carrier, a claim will be submitted with your private insurance on file. Should the private insurance deny the claim, you will become responsible for the entire balance of your services.
- It will be your responsibility to contact us with the name and address of your employer or the insurance company that covers your employer.

X-Ray Policy
- If you require an x-ray on today's visits, the x-ray will be sent out to a Radiologist for a second opinion for quality assurance purposes.
- You will be responsible for the cost of this service if your insurance company chooses not to cover it.

Overdue and Credit Balances
- All over-due patient balances will be sent to collections.
- All accounts sent to collections will be charged a $25 collection fee in addition to the account balance.
- Credit balances under $15 aged over 60 days may be written off.

Divorce or Custody Case Policy
- The parent or guardian who brings the patient into our office will be held financially responsible, regardless of the provisions in the divorce decree, or who has custody, or who has the insurance.

To help in this policy, we ask that you assist us by:

1. Providing us with current and updated information on yourself and your insurance company.
2. Presenting an updated photo identification card and insurance card when changes are made.
3. Making the appropriate payment at the time of service, whether it is a deductible, copay, coinsurance, or for the full amount if you are a Self-Pay Patient.

In order to provide the best medical care, we ask that you do not discuss your account balance or financial aspects with the physician(s) or medical staff. Please discuss any account information with the check out associate or front desk.

Your cooperation is greatly appreciated.