URGENT CARE PATIENT REGISTRATION

TO CONTROL COST OF BILLINGS, WE REQUEST PAYMENT FOR OFFICE VISITS AFTER EACH VISIT

LAST NAME	FIRST	MI	DOB

ADDRESS	CITY	ST	ZIP

PHONE	CELL	MALE	FEM

SINGLE ☐ MARRIED ☐ DEPENDENT ☐	SSN	Employer

RACE **HISPANIC OR LATINO YES☐ NO☐**

AMERICAN INDIAN☐ ALASKA NATIVE☐ ASIAN☐ BLACK/AFR AMER☐ ISLANDER☐ CAUCASIAN☐ DECLINE☐

FINANCIAL RESPONSIBILITY – IF PATIENT IS NOT OF AGE RESPONSIBLE PARTY

LAST NAME	FIRST NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT

ADDRESS	CITY	ST	ZIP

PHONE	Social Security Number	MALE ☐	FEMALE ☐

INSURANCE INFORMATION

INSURANCE CARRIER	ID NUMBER	GROUP NUMBER

POLICY HOLDER NAME	DOB

ADDRESS	CITY	ST	ZIP

EMPLOYER	CITY	STATE

SECONDARY INSURANCE	ID NUMBER	GROUP NUMBER

RELATIONSHIP TO POLICY HOLDER	SELF ☐ SPOUSE ☐ CHILD ☐	

EMERGENCY CONTACT

NAME	RELATIONSHIP	PHONE

ADDRESS	CITY	ST

LEAVE MESSAGE YES ☐ NO ☐	

I authorize the release of any medical information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for all medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, private insurance, and any other agency reimbursements to this center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges not paid by said Insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNATURE OF GUARANTOR

DATE

NOBLESVILLE URGENT CARE

Today's Date: ____/____/_____ **Insurance Carrier:** _____ **Copay:** _____
Fee For Service (FFS) Tier 1 2 3 (Do not send specimens to LabCorp!!!) Room # _____

BP:_____ HR:_____ RR:_____ T:_____Wt:_____ Ht:_____O2%:_____ Pain:_____ LMP:_____
POC(initial): FluA&B_____;StrepA_____;COVID-19 Antigen_____PCR_____;UA_____; other_____

Dear Patient**, please fill out everything below*: **Patient Intake Form** ***please fill out everything below:

Name: _____ **Date of Birth:** _____ **Age:** _____

Reason for visit? _____

Medication Allergies: _____

Have you had a Flu shot this season? ____Yes ____No; Would you like one today? ☐ YES ☐ NO
Are you currently (circle): PREGNANT BREASTFEEDING NEITHER

Did you test positive for COVID-19 AND have you been asymptomatic (no symptoms) for more than 24 days?	**___Yes**	**___No**
Did you complete a COVID-19 vaccination series more than 2 weeks ago?	**___Yes**	**___No**
Have you traveled outside of the U.S. within the last 30 days?	**___Yes**	**___No**
Spend 15 mins or more within 6ft of a person with COVID-19?	**___Yes**	**___No**
Provided care at home to someone who is sick with COVID-19?	**___Yes**	**___No**
Direct physical contact with someone who has COVID-19?	**___Yes**	**___No**
Shared eating / drinking utensils with a person with COVID-19?	**___Yes**	**___No**
Been sneezed / coughed on by a person with COVID-19?	**___Yes**	**___No**

Preferred Pharmacy & Location for sending electronic prescriptions: _____

Current Medications:

_____ _____
_____ _____
_____ _____

Past Medical History (circle): NONE High Blood Pressure Asthma COPD
Seizures Heart Failure GERD Depression Anxiety High Cholesterol
Stroke Hypothyroidism Hyperthyroidism Diabetes Type 1 Diabetes Type 2 Other

_____

Surgical History (indicate date if known): NONE Appendix Gall Bladder Tonsils
Cesarean Heart Bone/Joint (specify which) Other

_____

Family History (please circle family member by diagnosis): No Relevant History

Asthma	Mother	Father	Brother	Sister
Heart Attack	Mother	Father	Brother	Sister
High Blood Pressure	Mother	Father	Brother	Sister
Stroke	Mother	Father	Brother	Sister
Diabetes Type 2	Mother	Father	Brother	Sister
Cancer (please specify)_____	Mother	Father	Brother	Sister

Social History:

Do you use tobacco?	Yes/No	If yes, how many per day? _____	Week? _____ Month?_____
Do you use electronic cigarettes or vape?	Yes/No	If yes, how many cartriges per day? _____	Week? _____ Month? _____
Any alcohol use?	Yes/No	If yes, how often per day? _____	Week? _____ Month? _____
Any drug use?	Yes/No	If yes, which type? _____	

NOBLESVILLE URGENT CARE

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Noblesville Urgent Care to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). (The Notice of Privacy Practices provided by Noblesville Urgent Care describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Noblesville Urgent Care reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Office Manager, 509 Sheridan Rd. Noblesville, IN 46062.

I have the right to request that Noblesville Urgent Care restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

With this consent, Noblesville Urgent Care may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Noblesville Urgent Care may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

The following person(s) may contact Noblesville Urgent Care inquiring regarding my health information. You have my permission to release information to them.

Name _____ Relationship _____

Name _____ Relationship _____

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Noblesville Urgent Care may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable

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DISCLOSURE AND FINANCIAL AGREEMENT

CONSENT TO TREAT: I request and give consent to my physician to provide and perform such medical care, procedures, drugs, and other services and supplies as my physician, in his/her professional judgement deems necessary or beneficial.

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INURANCE BENEFITS: I authorize Noblesville Urgent Care and my physician to release information from my medical records to my insurance carrier(s), government agency, or my employer in the case of work-related injuries, for processing claims for medical/worker's compensation benefits and state on such claims that my signature if on file. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

FINANCIAL AGREEMENT: I understand all accounts are the full responsibility of the patient and/or the patient's responsible party guarantor. My physician will assist patients in obtaining insurance benefits when those benefits are assigned to my physician. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my physician.

TELEPHONE CONTACTS: I authorize Noblesville Urgent Care to contact me at the phone number(s) I have provided (whether such is my land line or cell phone).

RIGHT TO AMEND: If you feel that the medical information in your record is incorrect or incomplete, you may ask that it be amended. You must provide a reason that supports the request to amend. This does not apply to the deletion, erasure, removal or otherwise destruction of any part of the medical record.

RIGHT TO INSPECT AND COPY: You have the right to inspect and request copies of paper and electronic medical information that may be used to make decisions about your care as well as billing information, except for psychotherapy notes, information for civil or criminal proceedings, and certain information governed by the Clinical Laboratory Improvement Act. The facility may charge a fee for the cost of copying, mailing or transmitting records.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I have received the Practice's Notice of Privacy Practices and understand that the Practice may use my protected health information as described in the notice.

Patient Name/Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

NOBLESVILLE
URGENT CARE

Patient informed consent & Notice of disclaimer for treatment

The patient understands that the list below is provided as an example of services outside the scope of practice of Noblesville Urgent Care, and does not include all the services that may be considered to require specialized care beyond the treatment that is provided at Noblesville Urgent Care:

Life threatening events such as gunshot wounds, heart attacks, chest pain, headaches, strokes, pulmonary embolism, DVT, most shortness of breath, and serious infections, hospitalizations and treatment with other doctors, subspecialists, or providers at another healthcare organization.

Patients must agree to see a specialist physician when a medical problem is outside the scope of general medical care or for pre-existing conditions requiring a specialist as determined by our practitioner.

Patients with complicated medical conditions (i.e. diabetes, heart failure, seizure disorder, cancer, etc.) will be required to continue to follow up with their specialist based on the recommendations from the specialist. The practitioners at Noblesville Urgent Care will work in conjunction with the specialist to ensure quality care, and medicine refills when appropriate.

My signature below indicates that I have read and understand the above informed consent and disclaimer and I am consenting to treatment at Noblesville Urgent Care.

Patient signature: _____

Date: _____

AUTHORIZATIONS AND CONSENT TO TREAT A MINOR

I do hereby solemnly swear that I have legal custody of the aforementioned minor child.

Childs Name: _____ Date of Birth: _____

I grant my authorization and consent for Noblesville Urgent Care and its staff to administer treatment for any injuries or illness experienced by the minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize any and all professional emergency personnel to attend, transport, and treat the participant and to issue consent for any X-ray, anesthetic, medication, or other medical diagnosis, treatment, or care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, physician assistant, advanced registered nurse practitioner, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur.

It is understood that this authorization is given in advance of any such medical treatment.

_____ _____

Parent or legal Guardian's Signature Date:

NOBLESVILLE
URGENT CARE

Electronic Communication Consent and Release:

At Noblesville Urgent Care, various electronic means of communication may be used to treat and/or coordinate treatment with you and your family. Electronic communication may include, but is not limited to; cellular phone calls, text messages, e-mails, etc. When I exchange Protected Health Information electronically with a clinician from the Noblesville Urgent Care office, I am solely responsible for protecting my own privacy and confidentiality, at my own location. By signing this form, I acknowledge that I understand it is my responsibility alone to ensure the privacy of my end of any electronic communications. I hold Noblesville Urgent Care, and the providers blameless should any violation of my privacy occur due to my error.

If you would like to opt-in to receiving electronic communication from us please check which method or methods you would prefer.

	Email	
	Text Message	
	Phone	

_____

Date

_____

Signature

_____

If minor, please print name

_____

Witness

509 Sheridan Rd. - Noblesville, IN 46062 – Phone (317)678-6402 – Fax (317)678-6408

NOBLESVILLE URGENT CARE

Noblesville Urgent Care Symptom Screening

Top Box MUST be Completed!

Patient Name:_____ Date of Birth:_____

Symptom Screening: *Have you experienced any of these symptoms in the last 14 days?*

Fever (>100.4°F) or chills	□ **YES**	□ **NO**
Cough	□ YES	□ NO
Shortness of breath or difficulty breathing	□ YES	□ NO
Fatigue	□ YES	□ NO
Muscle or body aches	□ YES	□ NO
Headache	□ YES	□ NO
New loss of taste or smell	□ YES	□ NO
Sore throat	□ YES	□ NO
Congestion or runny nose	□ YES	□ NO
Nausea or vomiting	□ YES	□ NO
Diarrhea	□ YES	□ NO
Have you been in close contact with a person known/suspected to have Coronavirus (COVID-19)	□ YES	□ NO
Have you been diagnosed with COVID-19	□ YES	□ NO

Purpose of COVID-19 Viral (Antigen or PCR) Testing: *What is your reason(s) for testing?*

I have signs or symptoms consistent with COVID-19 If so, the date you start feeling sick: _____ OR how many days ago you start feeling sick? _____	□ YES	□ NO
I have been in close contact with a person known/suspected to have Coronavirus (COVID-19) If so, the date of exposure: _____ OR how many days ago you got exposed? _____	□ YES	□ NO
Public health surveillance	□ YES	□ NO
I have been diagnosed with COVID-19 and need test for resolution. If so, how many days have you been self-quarantine? _____ Please write test date(s): _____ and Please check test method(s): Antibody test(s): _____ or Viral test(s) (Nucleic Acid: _____ or Antigen: _____)	□ YES	□ NO
I plan to participate in special settings with vulnerable populations in close quarters for extended periods of time such as …	□ YES	□ NO
Surgery or Procedure	□ YES	□ NO
Travel	□ YES	□ NO
Nursing Home Facility	□ YES	□ NO
School or Sports	□ YES	□ NO
Work	□ YES	□ NO

 (Please remember to fill out both pages & then please sign page 2 also!)

NOBLESVILLE URGENT CARE

Noblesville Urgent Care Informed Consent for COVID-19 Viral (Antigen or PCR) Testing:

I give permission for Noblesville Urgent Care staff to perform COVID-19 viral (Antigen or PCR) testing. I certify that I have read through entirety of COVID-19 webpage on ***NoblesvilleUrgentCare.com*** for detailed COVID-19 test information, including the fact sheet for the Sofia 2 SARS Antigen FIA test & LabCorp's website for COVID-19 PCR Molecular Test. The testing process has been explained to me and I have had an opportunity to ask any questions.

I understand that COVID-19 viral testing can only be performed as part of an urgent care visit so I will see one of the providers who will help me to determine which COVID-19 viral testing is needed. *I will follow the return-to-work policy from your employer or school. I will call ISDH (Indiana State Department of Health) at 877-826-0011 (8 am to 5 pm daily) for further guidance.*

I understand that Noblesville Urgent Care cannot guarantee payment by my insurance company. I will receive a bill for anything not paid by my health insurance. If I have no insurance, I will pay the fee for the test in addition to the clinic visit fee. The fee for the Sofia 2 SARS Antigen FIA test [CPT 87426] is currently $100.00. I understand that I will receive a separate bill from LabCorp for the analysis of PCR Molecular Test.

I acknowledge that Noblesville Urgent Care cannot guarantee the accuracy of the result and that it may be necessary for me to undergo additional testing in the future. I recognize that even if I have a negative result now, I can still contract COVID-19 in the future. Administering the test does not create a patient/physician relationship between me and Noblesville Urgent Care or any of its employees, nor does it obligate Noblesville Urgent Care or its staff to perform any other care or treatment for me. I authorize Noblesville Urgent Care to receive my test results and convey them to me. I understand by undergoing the test Noblesville Urgent Care is required to report the results to the Indiana State Department of Health (ISDH) or other agencies.

I will continue to wear a mask in public to prevent new exposure to COVID-19.

I will continue to self-quarantine pending PCR Molecular test result from LabCorp.

If test result is POSITIVE, I will self-quarantine for at least 2 weeks and get in touch with ISDH (Indiana State Department of Health) for further instructions including contact tracing.

If I get sick including Trouble Breathing, Persistent pain or pressure in the chest, New confusion or inability to arouse, Bluish lips or face, I will go to nearby ER for further evaluation and treatment.

Name of Patient Printed: _____

Signature: _____

If minor, please sign by Legal Guardian and also print name of Legal Guardian

Date: _____

Witness: _____