

QUALITY PRIMARY CARE CO. d.b.a. FASTRACK URGENT CARE

room _____

Chief Complaint: _____

Last Name: _____ First Name: _____ MI: _____

Social Security #: _____ DOB: _____ Sex: M / F _____ Married? _____

Address: _____ City: _____ State: _____ Zip: _____

Cell/Phone: _____ Email: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Parent/Guardian: _____ Relationship: _____ DOB: _____ Phone: _____

Medications: _____

Allergies: _____

Pharmacy: _____

FINANCIAL POLICY & AUTHORIZATION

Payment & Insurance Assignment: I authorize payment directly to Quality Primary Care Co. for all insurance benefits. I understand that I am financially responsible for all charges, including copayments, deductibles, and non-covered services, whether or not paid by insurance.

Credit or Debit Card on File Authorization: To streamline billing and avoid late fees, I authorize Quality Primary Care Co. to charge copayments, deductibles, and non-covered services to my credit or debit card on file. I understand:

- This authorization remains in effect until the card expires or I provide written revocation
- Charges will be processed only for services rendered to me or my dependent(s)
- I will receive a patient statement and receipt after charges are processed

Collections & Late Fees: Returned check fee: \$30 or 10% of check amount (whichever is greater). Accounts unpaid for 90+ days will incur 1% monthly interest and may be referred to collections. Collection fees will be added to outstanding balances.

MEDICAL RECORDS RELEASE & HIPAA AUTHORIZATION

I authorize Quality Primary Care Co. to:

- Release medical records to my primary care physician and specialists involved in my care
- Disclose protected health information to insurance companies for billing and payment
- Share information with billing agents and collection agencies as necessary
- Use my signature on file for insurance submissions

HIPAA Privacy Notice: I acknowledge that Quality Primary Care Co.d.b.a Fastrack Urgent Care: Notice of Privacy Practices has been made available to me. I may request a copy at any time.

CONSENT TO TREATMENT & ACKNOWLEDGMENT OF RISKS

I consent to medical treatment for myself and/or my minor dependents at Quality Primary Care Co. I understand and acknowledge:

- 1. Nature of Urgent Care:** This is an urgent care facility, not an emergency room. Life-threatening conditions require 911 or hospital emergency department care.
- 2. No Guarantees:** Medicine is not an exact science. While providers will exercise reasonable care, no guarantees can be made regarding diagnosis, treatment outcomes, or results.
- 3. Diagnostic Imaging Limitations:** X-rays performed at this facility will be interpreted by a board-certified emergency medicine physician, not a radiologist. Formal radiologist over-reads are not routinely performed. Patients requiring specialist interpretation should follow up with their primary care provider or ER.
- 4. Follow-Up Care:** If symptoms persist, worsen, or new symptoms develop, additional evaluation (labs, imaging, specialist referral) may be necessary. I will seek appropriate follow-up care with my primary care physician or ER.
- 5. Test Results:** I am responsible for following up on all test results. Lab and imaging results will be communicated per facility policy. Failure to obtain results does not relieve me of responsibility for follow-up care.
- 6. Minor Consent:** I certify that I am the parent or legal guardian of any minor listed and have authority to consent to their medical treatment.

PATIENT or GUARDIAN SIGNATURE & ACKNOWLEDGMENT

I certify that the information provided is accurate and complete. I have read, understand, and agree to all terms above including financial responsibility, medical record release, and consent to treatment.

Signature of Responsible Party: _____ Date: _____

Printed Name: _____ Relationship: _____

For Office Use Only

Eligibility?: _____ Copay / Payment: \$ _____ cash / check / card initials _____

INSURANCE ELIGIBILITY

Last Name: _____ First Name: _____ MI: _____

PRIMARY INSURANCE

Insurance Company: _____ ID #: _____ Group#: _____ CoPay: _____

Policy Holder Name: _____ Relationship to Patient: _____

Policy Holder SSN: _____ DOB: _____ Employer: _____

SECONDARY INSURANCE (if applicable)

Insurance Company: _____ ID #: _____ Group#: _____

Policy Holder Name: _____ Relationship to Patient: _____

Policy Holder SSN: _____ DOB: _____ Employer: _____

PARENT OR GUARDIAN INFORMATION (for patients under 18)

Parent/Guardian Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

SSN: _____ DOB: _____ Phone: _____