NEW
PATIENT REGISTRATION

(Please Print Clearly)

Today's Date: _____

COVINA
URGENT CARE

605 E Badillo St, Covina, CA 91723

Patient _____

Last Name *First Name* *Middle Initial*

Sex: ☒ M ☐ F DOB: _____ Age: _____ Social Security #: _____

Address: _____ Apt #: _____

City/State/Zip Code: _____

Mobile Phone# _____ Home (Secondary) Phone# _____

Email: _____

Nearest Relative in Case of Emergency: _____ Phone # _____

To the best of my knowledge, there ☐ is ☒ is not any indication that I may now be pregnant _____

Allergies and **Medical Conditions** We Need to Be Aware Of:

_____

_____

List of Medications (we do not refill controlled meds, but as a courtesy we can refill non-controlled meds):

_____

_____

Preferred Pharmacy:

_____

Explain the **Reason** for Your Visit Today:

_____

_____

PROVIDE INSURANCE CARD TO RECEPTIONIST FOR BENEFITS VERIFICATION & MEDICAL CHART PREPARATION

IF PATIENT IS A MINOR THIS MUST BE FILLED OUT

Name of Parent / Guardian: _____ Phone #: _____

Address:_____ City/State/Zip Code: _____

Date Of Birth:_____ Social Security #: _____

Relationship of patient to responsible party: ☐ child ☐ other _____

VERIFIED BY: **INPUTTED BY:**

YOU SHOULD ALWAYS HAVE YOUR INSURANCE CARD IN YOUR WALLET

YOU MUST ANSWER YES TO #4 & #5
IN ORDER TO BE SEEN

1)	Do you have secondary health insurance?	YES	☐	NO	☐
2)	Are any of your injuries related to a car accident?	YES	☐	NO	☐
3)	Are any of your injuries sustained from a work-related injury?	YES	☐	NO	☐
4)	Do you agree to pay if your insurance does not pay?	**YES**	☐		
5)	You must inform staff if you are vomiting so we can provide you with assistance and vomit bags. You understand you will be charged $200 for leaving vomit or other body fluids / waste for others to clean up.	**YES**	☐		

IF YOU ANSWERED YES TO #2 OR #3 THERE WILL BE A CHARGE OF AT LEAST $100.00 PER VISIT AND WE WILL PROVIDE BILLING AND MEDICAL RECORDS TO YOUR ATTORNEY.

We keep a record of the health care services provided to you. Authority is granted for medical services to be performed and, in accordance with HIPAA standards, I also authorize requested public health information to be furnished to the health insurer or healthcare provider for the purpose of treatment, payment, and/or health care operations.

If my account is turned over to collections, I agree to assume the responsibility for all collection costs.

ASSIGNMENT AND RELEASE: I hereby authorize that my insurance benefits be paid directly to this facility. I am financially responsible for any balance due. I authorize Covina Urgent Care to release any information required to process this claim.

SIGNATURE: _____ DATE: _____

How did you hear about us?

- ○ Yelp
- ○ Newspaper
- ○ Internet
- ○ Friend
- ◉ Your Primary Care Doctor

We may contact you to ask about your experience here today.
Thank you for choosing our office to serve your urgent care needs. ☺

FINANCIAL POLICY

COVINA URGENT CARE

605 E Badillo St, Covina, CA 91723

Our financial policy helps us streamline operations in order to allow us to focus on what's most important: your health care. It is important to us that you understand our financial policies

1. Initials _____ **Co-payments are due at the time of service in accordance with your policy requirements.** We do not accept checks, but we do accept credit/debit cards. We do not bill for co-pays.

2. Initials_____ Please note this is an *after-hours* urgent care, therefore our cash price and insurance billing will account for this additional service. If you are concerned about the potential charges of using an urgent care center, please contact your insurance immediately.

3. Initials _____ If your health insurance benefits indicate that your deductible has not yet been met, we will collect a **$100 deductible deposit** which is used as payment towards the allowed amount of the visit. However, this $100 deposit payment might not satisfy the total cost of your visit. The total cost of your visit will be determined after we bill your insurance. If the total cost of the visit (the amount applied to your deductible) is determined to be more than $100 then we will bill you for that balance. (THIS IS IMPORTANT!! - Your initials here indicate that you understand.) If the deductible has been met, then the copayment or coinsurance amount (as stated in your health insurance benefits) would apply.

4. Initials _____ Please keep in mind that your insurance policy is a **contract between you and the insurer. If the insurer does not provide payment for your services within a reasonable period, we will have to bill you for payment**. If we are to receive payment from your insurer after you paid the balance, we will ***refund any overpayment***.

5. Initials _____ If you are insured by a plan we do not have a contract with, ***our charges for your consultation are payable at the time of service***. We will bill the claim as a ***courtesy to you***, but your policy benefits will ultimately determine the outcome of the billed claim.

6. Initials_____ If we are not able to verify your insurance, we will charge a deposit of $120. If your insurance processes your claim with a lesser liability, we will issue accordingly.

7. Initials _____ Payment is due upon receipt of a statement from our office. **If payment is not made within 30 DAYS from the original statement date, a $10 billing fee will be added. If payment is not received within 60 days from the original statement date an additional $35.00 collections fee will be added, and your account will be transferred to collections.**

8. Initials _____ Sales are final on ancillary products (splints, slings, etc.) and we will not seek to be reimbursed by your insurance. Any reimbursement by the insurance will have to be coordinated by the patient.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____

Signature of Patient (or responsible party) Date

_____

Name of Patient (PLEASE PRINT)

(626) 732-9232

Covina Urgent Care
Notice of Privacy Practices

605 E. Badillo Street
Covina, CA 91723

THIS LETTER DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-today activities and management of Covina Urgent Care. For example, information on the services you received may be used to support budgeting, financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed previously requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Covina Urgent Care Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.
We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Questions or Concerns
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Dario Castellanos, Administrator
Jose Gabriel Castellanos MD, INC.
234 E. Badillo St.
Covina, CA 91723
(626) 859 - 3297

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Effective Date
This notice is effective on or after **January 1, 2012**

Acknowledgement of Receipt of Notice of Privacy Practices

Covina Urgent Care reserves the right to modify the privacy practices outlined in the notice.

Signature

I have read the Notice of Privacy Practices for Covina Urgent Care, and I understand that I may request a copy.

_____

Name of Patient

_____

Signature of Patient

_____

Date

_____

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form.)

_____

Relationship of Patient Representative to Patient

Covina Urgent Care Record

605 E Badillo Street, Suite 110 Covina, CA 91723 (626)732-9232

Please Fill in Highlighted Areas In **BLACK INK** Only

Last Name	First Name	Age	Date of Birth	Today's Date

Sex M ☐ F ☐	Primary Care Physician	PCP Location (City, State):

Responsible Party (print): _____

Authorization: I consent to any medical or surgical treatment, or services rendered under the instructions of the physician. I also accept responsibility for all charges related to this treatment and authorize any insurance payments directly to Covina Urgent Care. Authority is granted, in accordance with HIPAA standards, to furnish requested public health information to the patient's health insurer or healthcare provider for the purpose of treatment, payment, and/or health care operations

Signature: _____ **Relation**: _____ **Date & Time**: _____

Please do NOT fill out below

Temp (F)	Pulse (bpm)	SpO2 (%)	Respiration (rpm)	Blood Pressure	Weight (lbs.)	Height	LMP	FBS (mg/dL)	MA Signature:
				/			/ /		☐ Name, DOB ☐ PCP ☐ Vitals CC

ALLERGIES: ☐ NKDA ☐ UKN ☐ PCN ☐ Sulfa

CHIEF COMPLAINT:

Problems	Days	Problems	Days	Orders	Results	Current Medications
☐ Fever		☐ Diarrhea		☐Strep		
☐ Cold		☐ Abdominal Pain		☐UA		
☐ Cough		☐ Rash		☐HCG		
☐ Sore Throat		☐ Headache		☐IPPB		
☐ Loss of Appetite		☐ Laceration		☐E.LAV		
☐ Earache				☐HHN		
☐ Vomiting				☐X-RAY		

S _____

_____

_____

O

Physical Examination	N	AB
General Appearance		
Skin		
HEENT / Neck		
Chest / Lungs		
Heart		
Abdomen		
Neuro		
Back & Extremities		

_____

_____

_____

_____

A _____

_____

_____

P _____

_____

INJSITE _____ **LOT#**_____ **INJ**_____ **ORAL**____ **MA**____

Provider Signature & Date _____

Provider Stamp: