# Community Urgent Care of Madison

30694 Hwy 72 Suite E • Madison, AL 35756
P: (256) 230-6130 F: (256) 230-6134

Patient Name: (Last) (First) (Middle)

Date of Birth: Sex: ☐ M ☐ F Race: Ethnicity: Marital Status:

Address: City: State: Zip Code:

SSN#: Home Phone: Cell: Work:

Email Address: Preferred Communication:

Emergency Contact: Phone Number: Relationship:

Employer: Employer Phone: Occupation:

Insurance Carrier: Policy#: Group #:

## IF MINOR

Father's Name: Date of Birth:

Address: City: State: Zip Code:

Employer: Employer Phone:

Mother's Name: Date of Birth:

Address: City: State: Zip Code:

Employer: Employer Phone:

## PRIVACY COMPLIANCE

Please list the family members or persons, if any, we may inform about your general medical condition and your diagnosis's which might include medical history, treatment, lab reports, x-rays, and treatment and/or reference to any mental or nervous disorders, drug and/or alcohol abuse, or sexually transmitted disease and billing inquiries.

Name: Relationship: Phone:

Name: Relationship: Phone:

**CAN CONFIDENTIAL MESSAGES BE LEFT ON HOME OR CELL VOICEMAIL?** **Yes** **No**

I hereby authorize Community Urgent Care of Madison to furnish to my primary physician and insurance company(s) all information which said physician or insurance company (s) may request. I hereby assign to Community Urgent Care of Madison all money to which I am entitled for medical/surgical expense relative to the services rendered but not to exceed my indebtedness to the professional company. I understand that I am financially responsible for all charges, whether paid, by said insurance. I hereby waive claims of exemption under the State of Alabama. I understand
There will be a $30.00 fee for returned checks. I agree to pay 27% of principal balance for collection costs should account be placed with a collection agency or attorney, plus court costs expended. I hereby give permission to Community Urgent Care of Madison to contact me via the numbers I have provided on issues associated with my account to include cellular numbers connected with me or my account. I understand that Community Urgent Care of Madison has a policy of random urine drug testing for all patients who are prescribed scheduled medications. Failure to provide a sample will disqualify me from receiving treatment at this facility. I permit a copy of this authorization to be used in place of this original.

Patient's Signature: Date:

Parent and/or Guardian's Signature: Date:

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ACCT #_____

**PATIENT MEDICAL HISTORY**

Community Urgent Care

| NAME (LAST, FIRST, MIDDLE | SOCIAL SECURITY # | DATE OF BIRTH AGE |
|---|---|---|
| | | |

****IN ORDER TO PROVIDE ADEQUATE TREATMENT, GATHERING DETAILED INFORMATION ABOUT YOUR PAST MEDICAL HISTORY, PAST PSYCHOLOGICAL HISTORY, FAMILY, AND SOCIAL HISTORY ARE VERY IMPORTANT. PLEASE ANSWER THE FOLLOWING QUESTIONS OPENLY AND SPECIFICALLY.**

**PLEASE CHECK THE BOX IF YOU HAVE EVER BEEN DIAGNOSED WITH ANY OF THESE PROBLEMS.**

| | | |
|---|---|---|
| Blood Clots or Free Bleeding | GI Disorders (acid/ulcers) | Kidney Disease |
| Cancer | Heart Disease (CHF/MI) | Lung Disease |
| Chronic Headaches | Hepatitis | Seizures |
| Chronic Pain | High Blood Pressure | Skin Disorders |
| Depression/mental disorder | High Cholesterol | Stroke |
| Diabetes | HIV/AIDS | Vascular Problems |
| Eye Disorder(retinopathy/glaucoma) | Hyperthyroidism | |
| Fibromyalgia | Joint Disease (gout/arthritis) | |

**PLEASE LIST ANY FAMILY MEMBER (MOTHER, FATHER, SIBLING, ETC.) THAT HAS OR IS CURRENTLY SUFFERING FROM THE ABOVE LIST.**

Condition: _____ Specific Family Member: _____

Condition: _____ Specific Family Member: _____

Condition: _____ Specific Family Member: _____

Condition: _____ Specific Family Member: _____

**PLEASE LIST ALL MEDICATIONS THAT ARE CURRENTLY PRESCRIBED TO YOU or OTC MEDICATIONS THAT YOU ARE TAKING:**

| NAME/STRENGTH/HOW YOU TAKE IT/PRESCRIBING DOCTOR | NAME/STRENGTH/HOW YOU TAKE IT/PRESCRIBING DOCTOR |
|---|---|
| | |
| | |
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| | |

**DO YOU HAVE AN ALLERGY TO ANY MEDICATIONS? NO YES IF YES, PLEASE LIST THE MEDICATION(S) BELOW:**

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**Social History: Single Married Divorced IF IN SCHOOL GRADE: _____**

**ARE YOU A: NONUSER OF TOBACCO SMOKER FORMER SMOKER USER OF SMOKELESS TOBACCO**

**PLEASE LIST PRIOR SURGERUES, PROCEDURES, OR HOSPITALIZATIONS AND THE PHYSICAN PERFORMED/ADMITTED BY:**

| | | |
|---|---|---|
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| | | |

**I certify by my signature that the information given on this form is correct to the best of my knowledge.**

**Patients Signature: _____ Date: _____**

**Parent and/or Guardian's Signature: _____ Date: _____**

# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____

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

Phone: _____ SSN: _____

Date of Request: _____ Type of Records Requested: _____

## PLEASE SEND MEDICAL RECORDS UPON REQUEST

### I AUTHORIZE COMMUNITY URGENT CARE OF MADISON TO RELEASE OR RECEIVE INFORMATION

Name of Provider/Facility: _____

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

Phone: _____ Fax: _____

I HEREBY AUTHORIZE THE RELEASE OF ANY AND ALL MEDICAL INFORMATION. INCLUDING DIAGNOSIS, TREATMENT, PROGNOSIS, ETC. OF THE INJURIES AND/OR ILLNESS RECEIVED BY THE ABOVE NAMER PERSON ON AND SUBSEQUENT TO THE DATE OF THE INJURIES AND/OR ILLNESS. AUTHORIZATION IS KEPT ON FILE UNLESS REVOKED IN WRITING.

Patient's Signature: _____ Date: _____

Parent/Legal Guardian: _____ Date: _____

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# CONSENT TO TREAT

Patient Name:_____ Date of Birth: _____

I authorize the providers at Community Urgent Care of Madison to perform necessary medical examinations and tests to diagnose and treat my health conditions.

I understand that I have the right to discuss any treatment with my provider and I am encouraged to ask questions about any concerns I may have.

_____

Patient Signature Date

_____

Parent/Guardian Signature (if patient is a minor) Date

**Insurance Type:**

**Patient Name:**

**Identification Number:**

Community Urgent Care

## Advance Beneficiary Notice of Non-Coverage (ABN)

**NOTE: If your insurance doesn't pay for D. services below, you may be responsible for the bill. Your insurance may not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect that there is a possibility your insurance may not pay for the D section below.**

| D services | E. Reasons ins may not cover | F. ESTIMATED COST |
|---|---|---|
| Office visit/ additional charges | Non-Covered | |

**What you need to do now:**

- **Read this notice, so that you can make an informed decision about your care.**
- **Ask us any questions that you may have after you're finished reading.**
- **Choose an option below about whether you want to go further with treatment. NOTE: If you choose option 1 or 2, we can help you with the balances. Just ask to talk to Mallory and we can see what we can do to make sure you get the best treatment possible, financially, and physically.**

| G: Options: | Check only one box | We can not choose a box for you |
|---|---|---|
| • OPTION 1: I want the D listed above and I would like my insurance billed for an official decision on payment, I understand that if my insurance doesn't pay, I am responsible for payment. If my insurance does not pay, Community Urgent Careo of Madison will refund any payments, less co-pays or deductibles.<br>• OPTION 2: I want the D listed above, but do not bill my insurance. I may be asked to pay now as I am responsible for payment. I cannot appeal if my insurance is not billed.<br>• OPTION 3: I do not want the D listed above. I understand with this choice I am not responsible for payment and I cannot appeal to see if my insurance would pay. | | |

**H. Additional Information:**

**This notice gives our option, not an official insurance decision. Signing below means that you have received and understood this notice. If you would like a copy, please let us know.**

| Signature: | Date: |
|---|---|
| | |

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