Glory Springs Urgent Care &
Healthcare Foundation
1023 W Fort Williams St.
Sylacauga, Alabama 35150

CONSENT, ASSIGNMENT, AND RELEASE FORM

CONSENT FOR MEDICAL TREATMENT

I voluntarily present to Glory Springs Urgent Care & Healthcare Foundation and consent to treatment of the physician on duty and whomever they may designate as their assistant, associate, treating physician and patient care staff to provide my care. Such care may include, but is notlimited to, diagnostic procedures, radiological evaluations and procedures, and the administration of medications considered advisable in my diagnosis, treatment, and course of care. I acknowledge that no guarantee can be made or has been made as to the results of treatments or examinations and I understand that all medical treatments contain inherent risks.

ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT GUARANTEE

In consideration of services provided, I hereby assign and transfer to Glory Springs Urgent Care & Healthcare Foundation any and all rights, which I have against insurance companies or third-party payers, for payment of charges for services provided by Glory Springs Urgent Care & Healthcare Foundation to meor to one of my dependents. I authorize said payments to be applied to any unpaid balance for which I am responsible.

I understand that I am responsible for and will pay the portion of my bill not covered by insurance companies or third-party payers. I agree to pay the account in full upon receipt of my billing statement unless payment arrangements are made with Physicians Urgent Care. If my account is placed with a collection agency, an additional 35% will be added to my balance. *It is our policy that any insurance co-pays and deductibles or any balance of a bill owed by those without insurance is due at the time of service.*

GOVERNMENT COMPLIANCE

In compliance with the recently enacted Patient Protection and Affordable Care Act and the Stark Law, Glory Springs Urgent Care & Healthcare Foundation must inform you that there are other options pertaining to laboratory, diagnostic, and radiographic services. Specifically, it should be noted that you have presented to Glory Springs Urgent Care & Healthcare Foundation voluntarily for your medical needs and that as part of the evaluation ofyour condition and any required treatment, the physician on duty may determine that laboratory, diagnostic, and radiographic tests may be needed. Glory Springs Urgent Care & Healthcare Foundation offers many of these services on-site as a convenience to our patients. Ifany patient would like to have their laboratory or radiographic services provided at another location, we can provide you with a listof nearby locations. Due to government laws and policies Glory Springs Urgent Care & Healthcare Foundation is not able to accept payment for laboratory, radiographic, or other ancillary services from Medicare, Secondary Medicare Plans, or Medicaid. If you have Medicare or Medicaid as your primary or secondary insurance it is your responsibility to inform the staff of Glory Springs Urgent Care & Healthcare Foundation of this so
that we may explain this law and its ramifications in more detail to you.

RELEASE AND USE OF PATIENT INFORMATION

I authorize the release of my medical records, information, treatment and advice, and specific health information to:

1. TREATING PHYSICIANS on staff at Glory Springs Urgent Care & Healthcare Foundation and their staff, agents of another healthcare facility if directtransfer to another facility is required, and to my primary care physician or any referred consultants for follow up care.
2. AN EMPLOYER who requests services. This may include your personal medical history, physical, laboratory and diagnostic tests, and drug screenings (including the presence of drugs, alcohol or marijuana).
3. INSURANCE COMPANY or other third-party payer and their agents as well as any review organization or government agency for the purpose of determining eligibility and available benefits, obtaining payment for services provided, and insuring government compliance.
4. EDUCATIONAL OR SCIENTIFIC INSTITUTIONS, authorized health care professionals in training, internal quality improvement, risk management and legal counsel when it is judged that my ongoing medical care, medical research, quality improvement, healthcare education or science will benefit; for any purpose authorized by law.

I understand that if I refuse to authorize access to my records for coordination of care, my treatment could be adversely effected and that I could be held liable for the full cost of services provided by Physicians Urgent Care. I understand this information may contain my personal medical history, physical, and treatments (if necessary), radiographic and laboratory results, and more specifically results in reference to alcohol/drug abuse, mental health, or infectious disease (including human immune-deficiency virus, hepatitis, or other infectious diseases). I understand that I have the right to revoke this authorization.

Printed Patient Name: _____

Signature of Patient or Parent/Guardian:_____Date: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO YOUR FAMILY OR OTHER INDIVIDUALS

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1966, in order for your physician or the staff of Glory Springs Urgent Care & Healthcare Foundation to give copies of and/or discuss your condition/exams/procedures/x-rays with members of your family or other individuals that you designate other than your primary care doctor or specialist, we must obtain your authorization prior to doing so.

In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

I authorize Glory Springs Urgent Care & Healthcare Foundation to release any and all information (including verbal information, copies of x-rays and medicalpaperwork) concerning my medical care to the following individuals:

Name:_____Relationship:_____Phone Number: _____

Name:_____Relationship:_____Phone Number: _____

_____I DO NOT authorize Glory Springs Urgent Care & Healthcare Foundation to release any information concerning my care to any individual.

_____I authorize Glory Springs Urgent Care & Healthcare Foundation to leave a detailed message on the following authorized phone number: _____

_____I DO NOT authorize Glory Springs Urgent Care & Healthcare Foundation to leave a detailed message on my answering machine or voicemail. I acknowledge that by choosing this option that I, the Patient, assume full responsibility for contacting Glory Springs Urgent Care & Healthcare Foundation forthe results of all testing.

Printed Patient Name: _____

Signature of Patient or Parent/Guardian:_____Date: _____

AUTHORIZATION TO DISCUSS FINANCIAL INFORMATION

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1966, we must obtain your authorization to discuss financial information with members of your family or other individuals that you designate other than insurance companies or third-party payers and their agents.

I authorize Glory Springs Urgent Care & Healthcare Foundation to verbally discuss financial information with:

Name:_____Relationship:_____Phone Number: _____

Name:_____Relationship:_____Phone Number: _____

Printed Patient Name: _____

Signature of Patient or Parent/Guardian:_____ Date: _____

RECEIPT OF HIPAA PRIVACY NOTICE

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how Glory Springs Urgent Care & Healthcare Foundation may use and disclose my protected health information. I understand that Glory Springs Urgent Care & Healthcare Foundation reserves the right to change the privacy noticeand that a copy of the revised notice will be made available to me.

Signature of Patient or Parent/Guardian:_____Date: _____

PATIENT INFORMATION

First Name: _____ MI: _____ Last: _____ Nick Name: _____

Home Phone: Work Phone: Cell Phone:

DOB: _____ ⌟ Male ⌟ Female SS#: _____

Address: City: State: Zip:

Employer: _____

State ID/Driver's License #: E-mail Address:

Name of Physician: _____ Physician Phone: _____

In case of Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about our office? _____

Patient Health History

Do you have a history of:

	Yes	No		Yes	No		Yes	No		Yes	No
A.I.D.S/HIV Positive	⌟	⌟	Excessive Bleeding	⌟	⌟	Jaundice	⌟	⌟	Respiratory Problems/Disorders	⌟	⌟
Alcoholism	⌟	⌟	Epilepsy	⌟	⌟	Kidney Disease	⌟	⌟	Rheumatic Fever	⌟	⌟
Allergies	⌟	⌟	Glaucoma	⌟	⌟	Kidney Dialysis	⌟	⌟	Rheumatism	⌟	⌟
Anemia	⌟	⌟	Hay fever	⌟	⌟	Latex Sensitivity	⌟	⌟	Scarlet Fever	⌟	⌟
Arthritis	⌟	⌟	Head injuries	⌟	⌟	Lupus	⌟	⌟	Seizures/Fainting spells	⌟	⌟
Asthma	⌟	⌟	Hearing Impaired	⌟	⌟	Low Blood Pressure	⌟	⌟	Sinus Problems	⌟	⌟
Blood Disease	⌟	⌟	Heart Disease	⌟	⌟	Malignancies	⌟	⌟	Stomach Ulcers	⌟	⌟
Bone Disease	⌟	⌟	Heart Valve, Murmur	⌟	⌟	Mitral Valve Prolapse	⌟	⌟	Stroke	⌟	⌟
Cancer	⌟	⌟	Hepatitis/Liver Disease	⌟	⌟	Neck & Back Problems	⌟	⌟	Thyroid Disease	⌟	⌟
Chemical Dependency	⌟	⌟	Type(s) _____			Nervous Problems/Disorders	⌟	⌟	Tuberculosis	⌟	⌟
Chest Pain	⌟	⌟	Hepatitis Carrier	⌟	⌟	Pacemaker	⌟	⌟	Tumors or growths	⌟	⌟
Circulatory Problems	⌟	⌟	High Blood Pressure	⌟	⌟	Prosthetic Joints	⌟	⌟	Ulcers	⌟	⌟
Convulsions/Seizures	⌟	⌟	Hip or Joint replacement	⌟	⌟	Psychiatric Care	⌟	⌟	Venereal Disease	⌟	⌟
Diabetes	⌟	⌟	HPV	⌟	⌟	Radiation Treatment	⌟	⌟			

Medical Questions

List any medications you are taking including nonprescription drugs:

_____

_____

Are you allergic to any medications? ⌟ YES ⌟ No If yes, please list below:

_____

_____

Are you in good health? ⌟ YES ⌟ No

Date of last medical exam: _____

Have you ever been hospitalized? ⌟ YES ⌟ No If yes, what was the problem

_____

Do you have any disease/problem you think we should know about? ⌟ YES ⌟ No

_____

_____

Have you had a transplant operation that has depressed your immune system? ⌟ YES ⌟ No

Have you had an allergic reaction to Bananas? ⌟ YES ⌟ No

Do you smoke or chew tobacco? ⌟ YES ⌟ No

Have you had Heart Surgery? ⌟ YES ⌟ No

Are you now under the care of an MD? ⌟ YES ⌟ No

Are you taking or have you ever taken bisphosphonates? (Fosamax or Actonel for osteoporosis, chemotherapy, etc) ⌟ YES ⌟ No

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Legally Separated ❑ Widowed ❑ Significant Other ❑ Life Partner ❑ Unknown

Preferred Language: _____ Race/Ethnicity _____

Primary Care Physician: _____

EMPLOYMENT STATUS: ❑ Full-Time ❑ Part-Time ❑ Unemployed ❑ Retired ❑ Self Employed ❑ Full-Time Student ❑ Part-Time Student

Patient's Employer: _____ Work Phone: (____) _____

Occupation: _____ Retirement Date: _____

RESPONSIBLE PARTY:

Name: _____

Relationship: ❑ Self ❑ Spouse ❑ Parent

Address (if different than above): _____

City/State/ZIP: _____

SSN: _____ Date of Birth: _____

Home Phone: (____) _____

Work Phone: (____) _____

Cell Phone: (____) _____

Employer: _____

If patient is a minor, are parents: ❑ Married ❑ Divorced ❑ Separated ❑ Never Married

Parent responsible for providing child's insurance: _____

Parent responsible for payment of medical expenses not covered by insurance: _____

EMERGENCY CONTACT #1

Name: _____

Relationship to Patient: _____

Address (if different than above): _____

City/State/ZIP: _____

Home Phone: (____) _____

Work Phone: (____) _____

Cell Phone: (____) _____

EMERGENCY CONTACT #2

Name: _____

Relationship to Patient: _____

Address (if different than above): _____

City/State/ZIP: _____

Home Phone: (____) _____

Work Phone: (____) _____

Cell Phone: (____) _____

ACCIDENT/INJURY: Is your visit due to a work-related injury? ❑ Yes ❑ No Motor vehicle accident? ❑ Yes ❑ No

INSURANCE INFORMATION – Please present insurance cards and photo ID for copying and complete the following:

Primary Insurance Company : _____ Subscriber/Member No: _____

Subscriber Name: _____ Subscriber Date of Birth: _____ Group No: _____

Subscriber Address: _____ City/State/Zip: _____

Patient relationship to subscriber: ❑ Self ❑ Spouse ❑ Domestic Partner ❑ Child ❑ Other: _____

Policy Effective Date: _____ Subscriber's Employer: _____

Secondary Insurance Company: _____ Subscriber/Member No: _____

Subscriber Name: _____ Subscriber Date of Birth: _____ Group No: _____

Subscriber Address: _____ City/State/Zip: _____

Patient relationship to subscriber: ❑ Self ❑ Spouse ❑ Domestic Partner ❑ Child ❑ Other: _____

Policy Effective Date: _____ Subscriber's Employer: _____

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