RedMed Urgent Clinic

PATIENT INFORMATION

Patient Name:	Date of Birth:	Social Security Number:	
		Sex: M F	Marital status: S M D W

Address: [Address/ P.O Box, City, ST ZIP Code]

Home phone number:	Cell phone number:
Employer:	Employer phone number:

PRIMARY INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Policy Holder/Guarantor's name:	Relationship to patient:	Birth date:	Social Security number:

Address: [Address/ P.O Box, City, ST ZIP Code]

Home phone number:	Cell phone number:
Employer:	Employer phone number:

SECONDARY INSURANCE INFORMATION

Policy Holder/Guarantor's name:	Relationship to patient:	Birth date:	Social Security number:

Address: [Address/ P.O Box, City, ST ZIP Code]

Home phone number:	Cell phone number:
Employer:	Employer phone number:

MEDICAL HISTORY

Drug Allergies:	Adequate Nutrition: Y N	Sudden Weight Loss: Y N	Sudden Weight Gain: Y N
Fall Risk: Have you fallen in the past 6 months? Y N	Abuse Screen: Are you being abused by anyone? Y N	Suicide Risk Screen: Any thoughts of harming yourself? Y N	

Please check if you have any of the following:

____Heart Disease/Heart Attack
____Stroke
____Diabetes
____Lung Problems
____Kidney Disease
____Stomach Ulcers/Disease
____Bowel Problems
____Hepatitis
____Urinary Problems
____Epilepsy/Seizures
____Thyroid
____Bleeding Disorders
____Hernia
____HIV
____Sexually Transmitted Infections/Disease
____Pelvic Infections
____Depression
____Mental Illness
____Lupus
____High Blood Pressure
____Previous Cancer—if so, what kind? _____

Do you have a family history with any of these conditions? (state relationship please)

Mother: M Father: F Brother: B Sister: S Grandmother: GM Grandfather: GF

____High Blood Pressure (Hypertension)
____Lung Disease
____Stroke
____Heart Disease/Heart Attack
____Sexually Transmitted Infections/Disease
____Previous Cancer—if so, what kind? _____

Past Surgeries or Hospitalizations: Date:

Have you been involved in a motor vehicle accident that brought you to the clinic today? Y N

REDMED URGENT CARE CLINICS DO NOT TREAT ANY MOTOR VEHICLE ACCIDENTS

Is your visit today related to a worker's comp injury? Y N (if so, please notify front desk immediately)

Do you smoke? Y N If so, how much? _____	Do you drink more than 2 alcoholic beverages on a daily basis? Y N	Do you use street drugs/narcotics? Y N If so, please explain: _____

PHARMACY/PRESCRIPTION INFORMATION

PHARMACY: PHARMACY PHONE NUMBER:

PRESENT MEDICATIONS/DOSAGE: WHO PRESCRIBED IT?

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COMMUNICATION

RedMed Urgent Care Clinic has the ability to provide patients with certain types of information via e-mail and/or text messaging. The types of information that can be communicated via e-mail/text with the patient include: appointment scheduling requests, billing and insurance questions, lab results, general questions, and patient education.

RedMed Urgent Care believes strongly in protecting the privacy of our patients. When you authorize RedMed Urgent Care to communicate with you via e-mail and/or text, it is only used as a way to communicate with you. Transmitting information via e-mail and/or text has a number of risks involved. By authorizing RedMed Urgent Care to e-mail and/or text, the patient is aware of the potential risks involved.

Please check one:

___I authorize RedMed Urgent Care Clinic to use e-mail or text as a communication tool. I understand the risks involved in using e-mail and/or text messaging to communicate with RedMed Urgent Care. This authorization will remain in effect unless I terminate the arrangement in writing. I agree to indemnify and hold harmless RedMed Urgent Care as the results of any issues arising from e-mail or text communications.

If agreed, please provide email and phone number:

_____

_____

___I DO NOT authorize RedMed Urgent Care Clinic to communicate via e-mail or text. This denial will remain in effect unless I updated my authorization in writing.

Patient/Guardian Signature

Date

REDMED URGENT CARE CLINIC

- STATE OF FINANCIAL RESPONSIBILITY: Unless otherwise prohibited, I unconditionally guarantee payment in full to RedMed Urgent Care Clinic, LLC.
- I hereby authorize and consent to the release of all medical and personal information (including but not limited to my home phone, cell phone, work phone, address and email address) by or to RedMed Urgent Care Clinic, LLC and all healthcare professionals involved in my care, interpretation of test results, account billing and collections, payment posting and/or claim processing, or related healthcare functions. This authorization shall remain in effect until such time as all account balances extending from the encounter have been fully satisfied.
- I authorize RedMed Urgent Care Clinic and all clinic providers who have provided care or interpreted my tests, along with any billing service, collection agency or attorney who may work on their behalf to contact me on my cell phone and/or home phone using pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology or by electronic mail, text messaging or by any other form of electronic communication.
- ASSIGNMENT OF INSURANCE BENEFITS: As a patient, I hereby make the assignment of benefits as set forth below.
- MEDICARE AND/OR MEDICAID: I request that payment of authorized Medicare/Medicaid benefits to or on my behalf for services furnished in or by RedMed shall be made to RedMed and I specifically assign such benefits to RedMed. I hereby certify that all information given by me in connection with applying for benefits under Title XVII of the Social Security Act is true, correct, and complete in all respects. I understand that payment for certain services not deemed medically necessary by Medicare/Medicaid are not authorized under Medicare/Medicaid Program and that I may be responsible for the entire charge incurred unless third party coverage is available. I also understand all deductibles are due unless they have been met within the period specified by Medicare.
- INSURANCE: I hereby assign to RedMed all rights, benefits, and interest under any insurance policy, health plan, workers' compensation, or third-party payor liable to me, in consideration for services rendered by RedMed. I hereby authorize payment directly to RedMed by any insurance policy, health plan, or third-party payor for treatment received at RedMed. I hereby authorize payment directly to RedMed for workers' compensation coverage for medical expenses for medical treatment received at RedMed. I hereby authorize payment directly to RedMed of all third-party liability insurance coverage, third-party payor, health plan, and individual liability insurance for medical expenses incurred as a results illness for which I received treatment at RedMed.
- To the extent allow by law, I remain responsible for any portion of the RedMed Urgent Care Clinic bill not paid by insurance, including co-insurance, denied claims or deductibles; I am responsible for any unpaid charges incurred.
- I understand on occasion, I might be treated by a new provider who is going through the insurance credentialing process, to be included in an insurance network. I understand that I, possibly, could be out of network for the new provider at RedMed. If my claim files out of network, I will bring to the RedMed Clinic my explanation of benefits to be evaluated.
- RELEASE OF INFORMATION: In addition to that provider above, RedMed Urgent Care Clinic may disclose all or part of my medical record when such disclosure is necessary for my continued treatment, the payment for the services I receive, for healthcare operation or as may be required or allowed by applicable law. I permit a copy of these authorizations and assignment to be used in place of the original.
- I authorize the provider assigned to furnish medical and surgical treatment by those means he/she considers necessary and proper in my treatment, identified below while I am a patient of RedMed Urgent Care Clinics. This treatment may require diagnostics procedures including but not limited to laboratory tests, blood drawing for those tests, x-rays and electrocardiogram.
- NOTICE OF PRIVACY PRACTICES: (check one of the boxes)

  □ Acknowledgement: I acknowledge that I have been offered, given, and received a copy of the RedMed LLC Notice of Privacy Practices. (My acknowledgement does not mean I agree with the Notice of Privacy Practices or that I have read the Notice of Privacy Practices, it only means I acknowledge receipt of a copy).

  □ Acknowledgement if patient is a minor or otherwise incompetent to sign: I hereby acknowledge that I have been given and received a copy of RedMed LLC Notice of Privacy Practices on behalf of the patient. (My acknowledgement does not mean I agree with the Notice of Privacy Practices or that I have read the Notice of Privacy Practices, it only means I acknowledge receipt of a copy).

  THIS IS TO CERITFY THAT I, THE UNDERSIGNED, BEING THE PATIENT OF ANOTHER PERSON LEGALLY AUTHORIZED TO ACT FOR THE PATIENT, HAVE READ THE ABOVE PARAGRAPHS.

_____

Patient/Guardian Signature

_____

Date

IN CASE OF EMERGENCY

RedMed will not discuss your personal health information or billing with anyone except those allowed under Federal and State law without your consent. Please list the name and relationship of those you authorize to discuss your personal health information with. We will use these authorized persons as your emergency contact, as well.

Name:	Relationship to patient:	Phone number:
Name:	Relationship to patient:	Phone number:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I, also, authorize RedMed or insurance company to release any information required to process my claims.

Patient/Guardian Signature

Date