

# Welcome to Premier

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## Patient Information

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_ Sex: F M Marital Status: S M D W

Mailing Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

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## Primary Insurance

None

Name/Policy Holder \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insurance Company \_\_\_\_\_ Patient's Relationship to Policy Holder \_\_\_\_\_

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## Secondary Insurance

None

Name/Policy Holder \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insurance Company \_\_\_\_\_ Patient's Relationship to Policy Holder \_\_\_\_\_

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## Financial Responsible

Same as Patient

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_ Sex: F M Marital Status: S M D W

Mailing Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

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**If you have been in an accident (auto, work, other), please ask for our Accident Form**

Patient Initials \_\_\_\_\_ Date \_\_\_\_\_

# Premier Urgent Care Privacy Practices

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**This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please read it carefully.**

From time to time, Premier Urgent Care uses and discloses confidential personal health information about patients. We know this information is private. We call this information "protected health information" (PHI). We are required to protect the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. This notice describes how we may use and disclose your PHI and certain rights you have with respect to your PHI.

## **Uses and Disclosures for Treatment, Payment and Health Care Operations**

HIPAA privacy rules permits us to use or disclose your PHI for the purposes of treatment, payment and healthcare operations, described in more detail below, without obtaining a specific written permission from you, known as an "authorization."

**FOR TREATMENT:** We may use or disclose information (PHI) about you to coordinate your healthcare. We may consult with other health care providers who are involved in your healthcare. For example, information may be shared to create and carry out a plan for your treatment.

**FOR PAYMENT:** We may use or disclose information to get payment for the healthcare services you receive. For example, we may provide PHI to bill your health plan for services provided to you.

**FOR HEALTHCARE OPERATIONS:** We may use or disclose information in performing business activities, which are called healthcare operations. Healthcare operations allow us to improve the quality of care we provide.

**APPOINTMENTS AND OTHER HEALTH INFORMATION:** We may send you reminders for medical services. We may send you information about health services that may be of interest to you.

## **Other uses and disclosures for which authorization is not required.**

In addition to using and disclosing PHI for treatment, payment and healthcare operations, the HIPAA Privacy Rule permits (or requires) us to use and disclose PHI without your written authorization under the circumstances described below:

**AS REQUIRED BY LAW AND FOR LAW ENFORCEMENT:** We will use and disclose information when required or permitted by federal or state law or by a court order. If federal or state law creates higher standards of privacy, we will follow the higher standard.

**FOR ABUSE REPORTS AND INVESTIGATIONS:** If we reasonably believe a patient has been a victim of abuse or neglect, we may disclose PHI as required by law.

**FOR GOVERNMENT PROGRAMS:** We may use and disclose information for public benefits under other government programs. For example, we may disclose information for the determination of Supplemental Security Income (SSI) benefits.

**TO AVOID HARM:** We may disclose PHI to law enforcement agencies in order to avoid a serious threat to the health, welfare and safety of a person or the public.

**FOR RESEARCH:** We may use information for studies and to develop reports.

**DISCLOSURES TO FAMILY, FRIENDS, AND OTHERS:** We may disclose information to the family or other persons who are involved in the patient's medical care. You have the right to object to the sharing of this information.

**Please list the names of the persons who we may disclose the patient's PHI and state how that person is related.**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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### Other uses and disclosures require your written authorization.

For other situations, we will ask for your written authorization before using or disclosing information. You may cancel this authorization at any time in writing. We cannot take back any uses or disclosures already made with your authorization.

### YOUR PRIVACY RIGHTS

**RIGHT TO INSPECT AND COPY MEDICAL RECORDS:** In most cases, you have the right to look at or get copies of your records. You must make the request in writing. You may be charged a fee for the cost of copying your records.

**RIGHT TO REQUEST RESTRICTIONS:** You have the right to ask us to limit how your information is used or disclosed. You must make the request in writing and tell us what information you want to limit and to whom you want the limits to apply. We are not required to agree to the limit. You can request in writing that the limit be terminated.

**RIGHT TO AMEND:** You may ask us to change or add missing information to your records if you think there is a mistake. You must make the request in writing, and provide a reason for your request.

**RIGHT TO OBTAIN A PAPER COPY:** You have the right to ask for a paper copy of this notice at any time.

**RIGHT TO FILE A COMPLAINT:** You have the right to file a complaint with us at the address listed below and with the Secretary of the United States Department of Health and Human Services if you do not agree about how we have used or disclosed information about you.

**RIGHT TO REVOKE PERMISSION:** If you are asked to sign an authorization to use or disclose information, you can cancel that authorization at any time. You must make the request in writing. This will not affect information that has already been shared.

**RIGHT TO CHOOSE HOW WE COMMUNICATE WITH YOU:** You have the right to ask that we share information with you in a certain way or in a certain place. For example, you can ask us to send information to your work address instead of your home address. You must make this request in writing. You do not have to explain the reason for your request.

**RIGHT TO RECEIVE NOTICE OF CHANGE TO PREMIER URGENT CARE PRIVACY STATEMENT:** You have the right to receive notice of changes in our privacy statement that affect you on or after the effective date of change. If you have any questions about this notice, the name and phone number of our contact person is listed on this page.

**Lynda Torres, Premier Urgent Care**

15854 Jackson Creek Parkway, Suite 120

Monument, CO 80132

(719) 481-2335

I hereby acknowledge that I have received a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights I may contact the person listed above. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified or changed in any way.

\_\_\_\_\_  
Patient or Representative Name

\_\_\_\_\_  
Patient or Representative Signature

\_\_\_\_\_  
Date

Patient or Representative refused or unable to sign because of \_\_\_\_\_

Date \_\_\_\_\_ Witnessed by \_\_\_\_\_

This notice was published and becomes effective on November 1, 2007

# Medical History

Patient Name \_\_\_\_\_ Gender M F Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Reason for Visit** \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Allergies \_\_\_\_\_

Current Medications (including herbs, supplements, over the counter meds) \_\_\_\_\_

Medical History (List all past/current medical conditions) \_\_\_\_\_

Surgical History: \_\_\_ Appendectomy \_\_\_ Gall bladder removal \_\_\_ Hysterectomy \_\_\_ Other: \_\_\_\_\_

**Please check positive social history below:**

Smoker:  No  Yes, \_\_\_\_ pack/day for \_\_\_\_ years  Quit

Alcohol:  Never  Rarely  Occasional  Quit

Recreational Drugs:  No  Yes, \_\_\_\_\_  Quit

Recently Traveled Abroad:  No  Yes, Location \_\_\_\_\_

Live Locally:  Yes  No, I live (where) \_\_\_\_\_

**Please check positive family history below:**

Mother:  Deceased  Diabetes  Asthma  Cancer  Hypertension  Coronary Heart Disease

Father:  Deceased  Diabetes  Asthma  Cancer  Hypertension  Coronary Heart Disease

Sibling:  Deceased  Diabetes  Asthma  Cancer  Hypertension  Coronary Heart Disease

Notes \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_

# Financial Policy

**Welcome to Premier Urgent Care! We are so glad that you've chosen us to provide your medical care today! If you have any questions regarding our payment policies, please ask us before your visit.**

## In Network and Auto (Accident) Insurance

We will submit your insurance claims for you. If you have had an auto accident, we will also require the claim number and mailing address of the insurance company. Please note that you are responsible for your copay at time of service. If coverage is denied for any reason, you will be responsible for the entire amount of your bill. **We have no way of quoting patient responsibility in advance. Individual insurance contracts vary, and we bill usual and customary fees according to our agreements with them. Your costs will be determined upon the completion of claims processing according to your individual insurance plan.**

**Tricare Prime patients only:** You are required to obtain an authorization to be seen. It is the patient's responsibility to obtain this referral. Ideally, this should be done prior to treatment. If this is not possible for whatever reason, then it is critical that you contact your PCM within one business day for this authorization. If authorization is not obtained, Tricare will apply the allowed amount for the visit to your deductible. If you receive a bill for your deductible, it is your responsibility to contact Tricare for payment.

## Out of Network Insurance

If you have insurance that is not listed on our contract list, you will be expected to pay the "no insurance" rates as listed below in full at time of service **or** we will courtesy bill your insurance one time. If no payment is made by your insurance, we will accept your "no insurance" payment as payment in full. If your insurance pays, we will issue you whatever refund may be due once we receive payment from your insurance. Refunds may take up to 60 days for processing. If you choose for us to bill your insurance and NOT pay the "no insurance" rates at time of service, please note that you may be billed the entire amount of your bill should your insurance deny your claim for any reason.

## No Insurance/International Insurance

If you do not have insurance or have international insurance, we expect you to pay for your visit in full at time of service. We will collect \$114 up front in order to see a doctor. Additional charges may apply depending on the extent of the visit and will be collected at the end of your visit. Our "no insurance" price sheet is available at the front desk. These rates are **ONLY** for patients with no insurance, out of network, or international insurance and are due at time of service. No discounts will apply if payment is not made immediately.

## Work Related (Work Comp)

The EMPLOYEE is responsible to report the Work Comp injury/illness in writing to the employer within four (4) days.

The EMPLOYER is responsible to fill out and mail a First Report of Injury to their insurance carrier within ten (10) days of injury notification.

The INSURANCE CARRIER is responsible to pay within thirty (30) days of receiving the Work Comp claim.

If the EMPLOYER fails to file the First Report of Injury, the EMPLOYEE must file his/her own First Report of Injury or be responsible for the bill.

If the INSURANCE CARRIER denies the claim for any reason, the patient (EMPLOYEE) will be responsible for the bill.

## Assignment of Insurance Benefits and Payment Guarantee

In consideration of services provided by Premier Urgent Care, I hereby assign and transfer to Premier any and all rights, which I have against insurance companies, governmental agencies, or third party payers, for payment of charges for services provided by Premier Urgent Care to me or to one of my dependents. I understand that I am responsible for and will pay the portion of my bill not covered by insurance companies, governmental agencies or third party payers. In consideration of services to be provided, I agree to pay Premier Urgent Care in accordance with the regular rates and terms of Premier Urgent Care. I further agree to pay the account in full upon receipt of my billing statement unless payment arrangements are made with Premier Urgent Care. I authorize said payments to be applied to any unpaid Premier balance for which I am responsible. Returned checks are subject to a \$25 service charge. Any balance over 60 days will acquire an interest rate of 12% annum. If my account is placed with a collection agency, an additional 25% will be added to my balance. I also agree, by my signature below, to pay all reasonable costs of collection including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs and understand that I may no longer be a patient at Premier Urgent Care. I have read and understand the payment policies and have been given the opportunity to ask questions about these policies. I understand my responsibility for payment of my account with Premier Urgent Care, and have provided to the best of my ability the information requested accurately and completely.

Signature of Patient/Guarantor \_\_\_\_\_ Date \_\_\_\_\_