Absolute QUICK CARE

REGISTRATION FORM

Please present your insurance card and photo ID at time of check-in.
Settlement of patient financial responsibility is expected at time of service.

Copayment Is Due At Time Of Visit. Self-pay (payment due at time of service)

PLEASE STOP NOW and NOTIFY the Receptionist Immediately
If YOU Are Experiencing any of the Following:
SEVERE chest pains **Severe shortness of breath**
Uncontrolled bleeding **Allergic reaction**
Any other life-threatening condition

Patient Information:
Please complete with patient's full legal name.

Last Name:_____ First Name:_____ MI____

Birth date:_____ SSN:_____ Gender :_____M_____F

Street Address:_____ City _____St: _____Zip:_____

Home Phone:_____ Cell Phone:_____

May we leave a message regarding your care? ___Y___N

Email:_____ Marital Status:_____

Occupation:_____ Work Phone:_____

Emergency Contact Name:_____ Phone:_____

Emergency Contact Relationship to patient:_____

Primary Care Physician:_____

Reason For Today's Visit:_____

How did you hear about us?[ ] Dr .Referral [ ] Existing patient [ ] Friend [ ] Internet
[ ] Phonebook [ ] Relative [ ] Road Signs [ ] Insurance [ ] Other_____

PLEASE LIST ANY **MEDICATIONS** THAT YOU ARE CURRENTLY TAKING **Dosage** and **Frequency**:

1. _____ **Dose/Strength** _____ **Times a day:**_____

2. _____ **Dose/Strength** _____ **Times a day:**_____

3. _____ **Dose/Strength** _____ **Times a day:**_____

4. _____ **Dose/Strength** _____ **Times a day:**_____

5. _____ **Dose/Strength** _____ **Times a day:**_____

6. _____ **Dose/Strength** _____ **Times a day:**_____

DO YOU HAVE ANY KNOWN **ALLERGIES TO MEDICATION** IF YES PLEASE LIST Them :

1._____**[ ]Rash [ ]Other**_____

2._____**[ ]Rash [ ]Other**_____

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS:
[ ] Diabetes
[ ] High Blood Pressure
[ ] High Cholesterol

Other Medical Conditions_____

ARE YOU A CURRENTLY A **SMOKER** ___Y___N If yes, for how many years_____
How much a day_____

Do You Drink **Alcohol**? Y__ N __ Preference:_____

Please List Any Past Surgeries and Year:

_____ _____ _____

_____ _____ _____

Family History-Does Anyone in your **Immediate Family:**

	High Blood Pressure	Diabetes	High Cholesterol
Mother			
Father			
Siblings			

Authorization and Release For All Treatment at this Facility

Authorization For Treatment: I voluntarily consent to the administration and cost of medical and surgical procedures, x-ray ,and medication for myself and my dependents.

Assignment of Insurance Benefits: I authorize payment directly to Absolute Quick Care for all benefits and the release of medical information for all services and payments otherwise payable to me.

Guarantee of Payment: I understand that I am financially responsible and agree to pay all of the charges that are not paid or billed to insurance or any other third party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance copays, coinsurances, and deductibles today. If you are unable to verify my insurance at time of service, I will pay in full for all services.

Release of Records: I authorize Absolute Quick Care to release(verbal or in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or other healthcare operations, which may be liable to me or practitioner(s) for charges for this treatment and for quality management, utilization review, transfer, and follow-up purposes.

Receipt of Privacy Practices: I acknowledge that I have received and read the Absolute Quick Care Notice of Privacy Practices.

I understand that a copy of this agreement may be used with the same effectiveness as the original.

Patient Signature_____ **Date**_____

Responsible Party_____ **Date**_____

Policyholder Information

Note: Please complete this section if the patient is **NOT** insurance policy holder, or is under 18 years of age.

Guarantor Name:_____Relationship:_____

Street Address:_____ City:_____ State:_____ Zip:_____

Phone Number:_____

Birth date:_____ SSN:_____

Employer:_____ Gender: M_____ F_____

RADIOLOGY

I understand that if my treatment requires radiology procedures (x-ray), it is my responsibility to inform the medical staff if I am pregnant or think I may be pregnant.

I understand that if symptoms persist I should seek additional medical care.

Signature: _____ **Date**:_____

Absolute Quick Care
Notice Of Privacy Practices

This Notice Describes How Medical Information About You May Be Used And Disclosed And How You can Get Access To This Information. Please review It Carefully.

This notice of privacy practices describes how Absolute Quick Care (we) may use and disclose your "protected health information" (PHI) to carry out treatment, payment and/or healthcare operations and for other purposes that are permitted or required by law. It describes your right to access and control your protected health information. Protected health information is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health condition and related healthcare services.

We are required to maintain the privacy of your health information and to provide you with a notice as to our legal duties and privacy practices with respect to information collected and maintained about you. We are required to abide by the terms of the Notice of Privacy Practices. We may change the terms of our notice at any time. any new notice will be given to you upon your request and will be effective for all PHI we maintain at that time.

How We May Use Or disclose Your Protected Health Information

The following categories describe ways we may use or disclose your protected health information. There are explanations of what we mean for each category of uses and disclosures.

*Treatment, payment and healthcare operations
Federal law permits Absolute Quick Care to use and disclose your PHI without your authorization or consent for the purposes of treatment, payment and healthcare operations.
*Treatment
We may disclose PHI to other healthcare providers who are responsible for your medical treatment. For example, we may provide other physicians, upon request, copies of various information to assist him/her in treating you.
*Payment
We may use or disclose information about you to determine coverage eligibility for insurance plan benefits, obtain copayment/coinsurance amounts and to facilitate payment for the treatment/services you receive from our healthcare providers.
*Healthcare Operations
Healthcare operations refer to business functions undertaken by Absolute Quick Care. operations may include referral/specialist, recommending treatment alternatives and or providing information regarding services that may be of interest to the individual. Information may be disclosed for purposes of medical review, legal services, audit services, and fraud abuse detection programs. We will share your protected health information for purposes of claim administration on behalf of your medical insurance plan.

Other uses and disclosures permitted without authorization
Federal law allows Absolute Quick Care to disclose PHI without your authorization or consent in the following ways:
* To you or a personal representative designated by you or designated by law to act for you.
* To the secretary of Health and Human Services or any employee of HHS as part of an investigation to determine our compliance with Federal Privacy laws.
*To the State Medical Review Board to respond to inquiries/ investigations of our practice or request audit.
* In response to a court order, subpoena, discovery requests or other lawful judicial or administrative proceeding.
*As required for law enforcement purposes. For example, to notify authorities of a criminal act.
* As required by law
* As required to comply with Worker's compensation and or other similar programs established by law.

Your Rights In Relation to Protected Health Information

Right to Request Restrictions on Uses and Disclosures
You have the right to request Absolute Quick Care to limit its uses and disclosures of PHI in relation to treatment, payment or healthcare operations. You also have the right to restrict the disclosure of PHI to family members or personal representatives. Any such request must be in writing and must state the specific restriction and to whom it applies.

I WISH TO DISCLOSE MY PROTECTED MEDICAL INFORMATION TO _____ **RELATIONSHIP:**_____
_____ **RELATIONSHIP:**_____
_____ **RELATIONSHIP:**_____

Right to Access Your Protected Health information
You have the right to copies of your PHI following the procedure of Absolute Quick Care. Federal law prohibits you from having access to psychotherapy notes: information for use in a civil, criminal or administrative action or proceeding. If your request for access is denied you may file a written complaint to: US Department of Health and Human Services 200 Independence Ave. SW Washington, DC 20201

Federal law indicates you read and sign this Notice as notification of your right to an accounting and disclosure rights pertaining to Private Health Information after April 14, 2003.

_____ _____
Patient(Parent/Guardian) Signature Date

Absolute QUICK CARE

NAME:_____

Sweats	□ Yes □ No	**Blood In Stool**	□ Yes □ No
Chills	□ Yes □ No	**Constipation**	□ Yes □ No
Fever	□ Yes □ No	**Diarrhea**	□ Yes □ No
Blurred Vision	□ Yes □ No	**Heartburn**	□ Yes □ No
Eye Pain	□ Yes □ No	**Nausea**	□ Yes □ No
Ear Pain	□ Yes □ No	**Vomiting**	□ Yes □ No
Sore throat	□ Yes □ No	**Blood In Urine**	□ Yes □ No
Shortness Of Breath	□ Yes □ No	**Frequent Urination**	□ Yes □ No
Chest Congestion	□ Yes □ No	**Painful Urination**	□ Yes □ No
Cough	□ Yes □ No	**Back Pain**	□ Yes □ No
Wheezing	□ Yes □ No	**Muscle Aches**	□ Yes □ No
Chest Pain	□ Yes □ No	**Painful Joints**	□ Yes □ No
Palpitations	□ Yes □ No	**Swollen Joints**	□ Yes □ No
Abdominal Pain	□ Yes □ No	**Weakness**	□ Yes □ No
New Lesions	□ Yes □ No	**Dizziness**	□ Yes □ No
Rash	□ Yes □ No	**Headache**	□ Yes □ No

PRIMARY CARE DOCTOR _____

PREFERRED PHARMACY_____