## ***PATIENT INFORMATION***

New pt Acct #30______

PATIENT NAME: ________________________________________________ TIME IN: ________
DATE OF BIRTH: _________________________SSN# __________-___________-________________
AGE: _________ SEX: ___________ MARITAL STATUS: _______________________________
HOME ADDRESS: _____________________________________________________________________
CITY: ___________________________________ STATE: __________________ ZIP CODE: ___________
HOME PHONE: _____________________________ CELL: _________________________________
EMAIL (TO EMAIL LAB RESULTS or IF WE NEED TO CONTACT YOU):
_______________________________________________@______________________________
EMPLOYER'S NAME: ______________________________________ OCCUPATION: ________________
WORK PHONE: ______________________________________
EMERGENCY CONTACT'S NAME: ________________________RELATIONSHIP TO PT: ________________
ADDRESS/ CITY/ STATE/ ZIP: _______________________________________________________
PHONE (provide their # in case we need to reach you):____________________________________

HOW WERE YOU REFERRED? __ WORKER'S COMP PRE-OP INS FRIEND WALK-IN Dr
WHAT IS THE NATURE OF YOUR ILLNESS/INJURY TODAY? _________________________________
_____________________________________________________________________________________

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? YES NO. (IF YES, INCLUDE ANY OVER THE COUNTER MEDICATIONS) ___________________________________________________________
_____________________________________________________________________________________
DO YOU HAVE ALLERGIES TO ANY MEDICATIONS? YES NO. IF YES, WHAT MEDICATIONS _____________________________________________________________________
DO YOU HAVE ANY PRE-EXISTING MEDICAL CONDITIONS? YES NO. IF YES, PLEASE INDICATE WHAT THEY ARE:____________________________________________________________

GUARANTOR/ RESPONSIBLE PARTY: ____________________________________ D.O.B. ______________
RELATIONSHIP TO PATIENT: __________________________ PHONE #: _______________________
ADDRESS/CITY/ STATE/ZIP: _______________________________________________________

PRIMARY INSURANCE CO.: ____________________________________________________________
SUBSCRIBER NAME(IF DEPENDENT/SPOUSE/CHILD): ______________________________________
ID #:__________________________________________ GROUP #: __________________________

PLEASE SIGN HERE x_______________________________________ ***DATE***: ________________

***CONTINUED ON NEXT PAGE*** **(Page 1 of 4)**

**Isidore Kwaw, M.D. President and Medical Director**
**910 Via De La Paz #100**
**Pacific Palisades, CA 90272**
**Tel: (310) 459-1901 Fax: (310) 459-1991**

***AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION/ AUTHORIZATION FOR MEDICAL TREATMENT***

PRINT PATIENT NAME: ____________________________________________

DATE OF BIRTH: ________-________-________
(MONTH) (DAY) (YEAR)

SOCIAL SECURITY: ________-______-_______

I HEREBY AUTHORIZE SUNSET URGENT CARE TO RELEASE ANY MEDICAL RECORDS, REPORTS, OR DR'S NOTES TO MY INSURANCE COMPANY IF NEEDED FOR REVIEW OR IN ORDER FOR PAYMENT TO BE MADE.

PATIENT SIGNATURE: **X**_____________________________________

DATE SIGNED: ________________

**HBA LLP**

CONSENT FOR TELEPHONIC COMMUNICATIONS

I, patient/responsible party understand that by engaging the services of ***Sunset Urgent Care Medical Center, Inc. / Dr. Isidore Kwaw*** ("Healthcare Service Provider") it will be important for Healthcare Service Provider and/or the "Authorized Entities" (as defined below) to have current contact information to communicate with me about diagnosis, treatment, prescriptions, insurance, surveys, research, billing and payment matters, or other related purposes.

**Authorized Entities:** The term "Authorized Entities" shall mean the above referenced Healthcare Service Provider, physicians, pharmacies, emergency room, radiologist, health care provider, servicer, independent contractor, and all of their billing services, collection agencies, or business associates, including, but not limited to, those persons and entities which are located at the same physical location as Healthcare Service Provider or to which Healthcare Service Provider has referred services, and each of their respective successors, assigns, subsidiaries, affiliates, billing service(s), collection agencies, healthcare accounts receivables management companies, debt collectors, or any person/entity in privity with any of them.

## Voluntary Communication Consent:

By signing this Consent for Telephonic Communications, I agree that Healthcare Service Provider and the Authorized Entities, and any of them, may communicate with me about diagnosis, treatment, insurance, surveys, research, billing, and payment matters, using prerecorded or artificial voice calls, text messages, and calls or messages delivered by an automatic telephone dialing system, to any telephone number I provide.

I understand that my agreement to this Consent for Telephonic Communications is not a condition to receive healthcare services. I further agree and promise to immediately notify Healthcare Service Provider and Authorized Entities whenever any of my telephone numbers or contact information changes or is no longer used by me. Healthcare Service Provider and Authorized Entities will treat any email address I provide as my private email that is not accessible by unauthorized parties.

I agree that a photocopy of this Consent for Telephonic Communications will be considered as valid as the original.

Signed: ____________________________________________ Date: ____________________

Print Name: ________________________________________________________________________

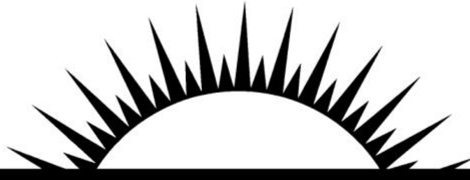
Check one: [ Patient ] Parent] Guardian] Responsible Party

My telephone numbers: ______________________________________________________________

## DISCLAIMER

By using this Consent for Telephonic Communication in any way, the Healthcare Service Provider and the Authorized Entities assume all risks of liability and hereby release CMRE Financial Services, Inc., Carlson & Messer LLP, and HBA LLP from any liability associated with this Consent for Telephonic Communications form. Any content included in this Consent for Telephonic Communications is presented for informational and general reference purposes only. CMRE Financial Services, Inc., Carlson & Messer LLP, and HBA LLP, and provide this Consent for Communications as a courtesy to be used for informational purposes only. The Consent for Telephonic Communications is not intended to serve as legal or other advice. CMRE Financial Services, Inc., Carlson & Messer LLP, and HBA LLP do not represent or warrant that the Consent for Telephonic Communications is accurate, complete or current for any specific or particular purpose or application. The Consent for Telephonic Communications is not intended to be a full or exhaustive explanation of the law in any area, nor should it be used to replace the advice of your own legal counsel.

**CONTINUED ON NEXT PAGE** 

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**Patient Agreement.**

By signing this agreement, the patient understands that he or she is financially responsible for the injections and/or medical supplies received from this office. The patient may pay up front or have this billed to their insurance company, however any charges not covered by the insurance company is the patient's responsibility.

Actual plan benefits cannot be determined until the claim is received by your insurance company and is based on their determination on medical necessity.

X_______________________________________________________________

Print Patient Name

X

Patient Signature or Responsible Person Date

Relationship to patient if not patient