Initials

MEDSTAR URGENT CARE

601 E FM 544, Suite 400, Murphy, TX, 75094
TEL: 972-442-4700 FAX: 972-442-1140

Initial Clinical History and Physical Form

Patient Information

Name: ___________________________________ Age: _____ Date of Birth: _____ /_____ /_____

Sex: Male / Female **Marital Status:** Single Married Divorced Widowed # Children _____

Reason for Visit: ____

____

Past Medical History

1.________________________ 5.________________________ 9.________________________
2.________________________ 6.________________________ 10.________________________
3.________________________ 7.________________________
4.________________________ 8 ________________________

Past Surgical History (Please include Year**)** **Last Tetanus:** _____________**year**

1. ___________________________________ 4. ________________________
2. ___________________________________ 5. ________________________
3. ___________________________________ 6. ________________________

Medications (Medication Dose)
1. ___________________________________ 4. ________________________
2. ___________________________________ 5. ________________________
3. ___________________________________ 6. ________________________

Drug Allergies /Type of Reaction
1. ___________________________________ 4. ________________________
2. ___________________________________ 5. ________________________
3. ___________________________________

Family Medical History

1.________________
2.________________
3.________________
4.________________
5.________________
6.________________
7.________________

Social History
Tobacco Use Y / N
______ Packs per day for
______yrs.

Alcohol Use Y / N

Drinks Per Week _________
for___________ yrs.

Recreational Drug Use Y / N

Name:

For ___________years.

__________________________ __________________________
Patient / Guardian Name Signature

_______/______/_________
Date

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Patient Registration Form

Patient Information

Last Name____________________________ First Name: ______________________________ Date of birth_________________

Age___________ Sex: M_____ F_____ Social Security: __________--____________--___________

Home Phone: _______________________________ Cell: __________________________________

Mailing address ______________________________ City ____________ State: ______

Zip Code/ Postal __________ Email: _____________________________________

Does Patient have Insurance? / Yes ____ No____ Insurance: _________________________

Subscriber's name: _________________________ SS# _____-______-______ DOB_______________

Parent/Guardian Information

Parent /Guardian Name: #1: _____________________________________DOB______________________

Mailing address: ______________________________ City: ____________ State: ______

Zip Code/ Postal: __________ Home Phone: _______________ Cell: ____________________

Occupation: ____________________ Work Address: _________________________

City: ___________State:______ Zip Code: ____________ Work # _________________

Parent /Guardian Name: #2: ______________________________DOB__________________________

Mailing address/: ______________________________ City: ____________ State: ______

Zip Code: __________ Home Phone/: _______________ Cell: _____________

Occupation: ____________________Work Address_______________

City: ___________State/________________ Zip Code/ Postal: ____________ Work #____________

Emergency Contact: (Required)

Name: ____

Address: ____

Relationship: ______________________ Telephone Number: ________________________

Signature____________________________

Do you permit us to discuss your ☐ YES ☐ NO <u>Medical History</u> ☐ YES ☐ No Results

☐ Yes ☐ NO Billing Information, with this person.

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Consent for Treatment

Name of Patient: ___________________________________ Date of Birth: _____/_______/________

Name of person giving consent if different from patient:

Name: ____ Relationship to Patient: ______________________________

I, hereby and voluntarily consent to authorize MEDSTAR URGENT CARE healthcare providers to provide, including but not limited to, evaluation, testing (including HIV and Drug screening including alcohol), / treatment & healthcare services to me/ My child at all locations. The health care services may include, without limitation, routine physical and mental assessment; Mental health treatment, genetic testing; counselling; diagnostic and monitoring tests and procedures; examinations and medical and/or dental treatment; routine laboratory procedures and tests; x-rays and other imaging studies; administration of medications and vaccination; and procedures and treatments prescribed by the center's healthcare Providers / Staff. I authorize release of any information concerning me / my child health information, including but not limited to counseling, test, treatment and Insurance information for the purpose of Evaluation, treatment and insurance claim benefits. I also Authorize to E prescribe my medications and supplies to the Pharmacy. I authorize Medstar Urgent Care to obtain my / My child's Medical History/ Records regarding my medication from third part, Pharmacy, Hospital, Medical Office, Imaging center and other appropriate medical facilities. I authorize Medstar Urgent care to send my test to other laboratory for testing and my health and payer Information to the Laboratory. I acknowledge that I will receive a bill from the Laboratory and I will be responsible for the Laboratory payment. There may be a portion of billing / Medical Equipment that is not covered by insurance and I will be responsible for the balance. I understand that I am responsible for charges due to services I receive that are not paid by my insurance. I realize that although every effort will be made to keep all risks and side effects to minimum, risks, side effects and complications can be unpredictable both in nature and severity.

I understand that this consent is valid and remains in effect as long as I am a patient of MEDSTAR URGENT CARE, until I withdraw my consent, or until MEDSTAR URGENT CARE changes its services and asks me to complete new consent forms.

My Signature on this form indicates that: I certify that I have read and fully understand the foregoing consent and the facts indicated above are true.

____/___________/_________

Signature of Patient/Legal Representative Date

____/___________/_________

Signature of Witness Date

Print Name of Witness: ____

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Patient Name: ______________________ DOB: _______________________

I. USE AND DISCLOSURE OF HEALTH INFORMATION

Initials _______I hereby authorize MedStar Urgent Care and its Staff to Disclose (release), Use and/or Request my protected Health information to/from: All medical organizations that I am referred to/from for my continuity of care. I also understand that MedStar Urgent care is permitted to use and disclosure my Health Information as required by law, such as workers' compensation, reporting top public health entities to include reporting to the Department of State Health Services Immunization Registry (ImmTrac), reporting abuse, neglect or domestic violence, judicial and administrative proceedings, law enforcement purposes, death reports, organ donation purposes, or to avert serious threat to public health or safety. MedStar Urgent Care is permitted to use and disclose my Health Information for treatment, payment and health care operations.

II. NOTICE OF PATIENT RIGHTS AND OTHER INFORMATION

Initials _________I understand that I may refuse to sign this authorization. I may obtain a copy of the health information whose use or disclosure I am hereby authorizing. I acknowledge that information disclosed pursuant to this Authorization may no longer be protected by applicable laws, and could be re-disclosed by the recipient. I understand that I have a right to receive a copy of this authorization. I may revoke this Authorization at any time, but I must do so in writing and submit it to address below. I understand that my revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

Initials _________ I understand and agree that it is my responsibility to know the benefits and Network of my insurance and not Medstar Urgent care and its staff. Also to be aware of my Co-Payment, deductible and Coinsurance in an out of network provider and facility.

Initials ________ I Give Medstar Urgent care consent to contact me / emergency contact for follow up and discuss test results. I also give permission to leave a message over the phone.

Initials _________ I agree to pay and understand my financial responsibility for any services or equipment (Including Durable Medical Equipment)) not covered by insurance.

Initials ________ I give consent to Medstar Urgent Care to bill my health insurance for the services that will be rendered to me or my family member.

III. SIGNATURE

I have read this release, fully understand its terms, and understand that I am giving up substantial rights, consistent with the state and federal laws and regulations concerning the privacy of such information.
I acknowledge that I am signing the release freely and voluntarily, and intend by my signature to be a complete and unconditional release of all liability to the greatest extent allowed by law.

Signature of Patient/ Guardian: _______________________________Date: _______/_________/_______

Name of Patient / Guardian: __________________________________Date:_______/_________/_______

Witness: _______________________________Print Name:___________________________

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Credit Card Payment Authorization Form

Sign and complete this form to authorize MEDSTAR URGENT CARE to charge your Debit / Credit Card.

By signing this form you give us permission to Charge your Credit / Debit Card. We do not hold or save your credit card information, neither we take card over the telephone. You are charged only at time of visit. This Authorization will remain in effect until written request is received by MedStar Urgent Care as per patient's request in writing and submitted to the Medstar Urgent Care mailing address.

I ______________________________ authorize MEDSTAR URGENT CARE to charge my credit card / Debit card / Apple Pay for, including but not limited to, the services, tests and Equipment provided to Me / My child / Family Member.

SIGNATURE ____________________________ DATE ____________________

Name: ______________________________ Relation: _________________________

I authorize the above named business to charge the credit card/ Debit card indicated in this authorization form according to the terms outlined above and is valid for recurrent visit. I certify that I am an authorized user of this credit/ Debit card and that I will not dispute the payment with my credit / Debit Card Company; so long as the transaction corresponds to the terms indicated in this form.

___

I acknowledge that MEDSTAR has made their Notice of Privacy Practices available to me.

_________________________________ _________________________________

Signature of Patient or Patient's Representative Relationship to Patient

_________________________________ _________________________________

Date Witness

All Rights Reserved Medstar PLLC