BEYOND Urgent Care

Date of Birth ____/____/____ Address _____

Last Name _____ Apt _____ Home Phone ( )____-____

First Name _____ City _____ Cell Phone ( )____-____

Middle Initial _____ State _____ Zip _____ Preferred Home Mobile/Work

Social Security #_____-_____-_____ Email _____

Sex ☐ M ☐ F

Emergency Contact Name_____ Phone_____ Relation _____

Patient Employed By_____ Work Phone_____

PARENT/GUARANTOR INFORMATION

Name (Last, First, Middle) _____

Date of Birth____/____/____ Social Security #_____ Sex M F

Address_____ City_____ State____ Zip_____

Home Phone_____ Mobile/Work Phone_____ Preferred Home Mobile/Work

Relationship to Patient Parent Guardian Spouse

PRIMARY INSURANCE

Carrier _____

Member ID_____ Group # _____

Insurance Claims Address _____

Phone _____

Policy Holder Name _____

Date of Birth____/____/____ Sex M F

Address _____

Relationship to Patient: Parent Guardian Spouse

SECONDARY INSURANCE

Carrier_____

Member ID_____ Group # _____

Insurance Claims Address _____

Phone _____

Policy Holder Name _____

Date of Birth____/____/____ Sex M F Address_

Relationship to Patient Parent Guardian Spouse

AUTHORIZATION AND RELEASE

Authorization of Treatment: By signing this consent form, I voluntarily consent to the administration and cost of medical and surgical procedures, x-ray(s) and medication(s) for myself and my dependents.

_____Initial: **I understand Beyond Urgent Care is a Free Standing Urgent Care Facility, and is billed as an Urgent Care visit to my insurance carrier.**

Guarantee of Payment:

____**Initial: SELF PAY: I elect to pay for all services rendered in full today. I understand that my insurance will NOT be billed by Beyond Urgent Care.**

____**Initial: Assignment of Insurance Benefits**: By signing this consent form, I authorize payment directly to Beyond Urgent Care (BUC) for all benefits other- wise payable to me. **I also acknowledge that BUC will submit my bill to my insurance carrier as a courtesy; however, I am ultimately responsible for all charges incurred, unless both parties mutually agree otherwise.** I agree that I will pay my estimated balance based on the best available information of my current policy. I understand this is only an estimate. While BUC makes every effort to verify my correct insurance information prior to leaving, I understand BUC cannot guarantee the accuracy of my bill until it has been fully processed by my insurance carrier.

Patient/Responsible Party Signature_____ Date _____

DISCLAIMER: ALL REFERENCES TO BEYOND URGENT CARE INCLUDE ITS AFFILIATE BETHEL URGENT CARE CENTER LLC

BEYOND Urgent Care

ADDITIONAL INFORMATION (PLEASE FILL IN COMPLETELY, ALL INFORMATION REQUIRED)

Patient's Name: _____ Date of Birth_____/_____/_____.

Marital Status: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

Ethnicity: ☐ HISPANIC/LATINO ☐ NON-HISPANIC RACE: _____ PREF. LANGUAGE: _____

REASON FOR VISIT: _____ DATE: _____

WHO IS YOUR (PCP) PRIMARY CARE PHYSICIAN? _____

WHEN WAS YOUR LAST VISIT TO YOUR PCP? LESS THAN 6 MONTHS MORE THAN 6 MONTHS MORE THAN 1 YEAR

CURRENT MEDICATIONS: NONE

DRUG: _____ DOSAGE: _____ FREQUENCY: _____

DRUG: _____ DOSAGE: _____ FREQUENCY: _____

DRUG: _____ DOSAGE: _____ FREQUENCY: _____

DRUG: _____ DOSAGE: _____ FREQUENCY: _____

DRUG: _____ DOSAGE: _____ FREQUENCY: _____

MEDICATION ALLERGIES: NONE _____ **OTHER ALLERGIES:** _____

WOULD YOU LIKE AN ALLERGY TEST? YES NO

PHARMACY: _____ TELEPHONE _____ ADDRESS: _____

HISTORY

MEDICAL HISTORY: NON-CONTRIBUTORY (CIRCLE ALL THAT APPLY)

ACID REFLUX ASTHMA HEART DISEASE CANCER (TYPE) _____

ANEMIA DIABETES HIGH BLOOD PRESSURE DEPRESSION SEIZURES THYROID DISEASE KIDNEY DISEASE

OTHER (S) EXPLAIN: _____

SURGICAL HISTORY:

TYPE: _____

TYPE: _____

FAMILY HISTORY: NON-CONTRIBUTORY

DEPRESSION ASTHMA HEART DISEASE DIABETES CANCER (TYPE) _____

HIGH CHOLESTEROL OTHER (EXPLAIN) _____

SOCIAL HISTORY: NON-CONTRIBUTORY OCCUPATION: _____ FULL-TIME PART-TIME

SMOKER? YES NO NUMBER OF PACKS PER DAY? _____ SUBSTANCE ABUSE? YES NO ALCOHOL ABUSE? YES NO

OFFICE USE ONLY:

CHIEF COMPLAINT: _____

_____

_____

_____

_____

TEMP: _____ RR: _____ PR: _____ 02: _____ BP: _____ WT: _____

HT: _____ Flu: _____ Strep: _____ Mono: _____

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PRIVACY PRACTICES

Receipt of Privacy Practices: I acknowledge that a copy of the Notice of Privacy Practices of Beyond Urgent Care is available to me upon request and can be downloaded at **www.beyondurgentcaremed.com.** I understand that a copy of this consent form may be used with the same effectiveness as the original.

PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS

Release of Medical Records: By signing this form I authorize Beyond Urgent Care (BUC) to release verbally, electronically, and/or in writing confidential medical information for purposes of treatment, payment of charges, quality assurance and utilization review, transfer and follow-up procedures to my insurance carrier, employer (if treatment is related to employment), other healthcare provider (s), and the following person (s).

Name:_____ Name:_____

Relation:_____ Relation:_____

Phone: _____ Phone: _____

□ I hereby authorize the release of my **COMPLETE** health record (including records relating to mental health care, communicable disease, HIV or AIDS, and treatment of alcohol/drug abuse).

OR

□ I hereby authorize the release of my **COMPLETE** health record **WITH EXCEPTION** of the following information:

- □ Mental health records
- □ Communicable diseases (including HIV and AIDS)
- □ Alcohol/drug abuse treatment
- □ Financial Account information
- □ Other (please specify):_____

OR

□ I hereby authorize the release of following information:

- □ Records for dates of service from_____to _____
- □ Narrative reports □ Lab results □Hospital records □ Pathology results
- □ Radiology results

Patient Signature:_____ **Date:** _____

ANCILLARY SERVICES

Our physician may recommend certain laboratory and/or radiology tests to help aid in the treatment and diagnosis of your condition. Some of these services are not routinely performed in our facility. For example, certain laboratory specimens are sent out to an independent lab for analysis. If this occurs, the lab will bill separately for their services. Should an X-Ray be performed in our facility, an independent radiologist will interpret these exams and report findings.

INITIAL _____

PATIENT RIGHTS

I acknowledge I have reviewed and received a copy of "Patient Rights and Responsibilities" from Beyond Urgent Care.

Patient Signature:_____ **Date:** _____

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WELLNESS UPDATE

PATIENT NAME: _____ DOB: _____

DO YOU EXPERIENCE ANY OF THE FOLLOWING SYMPTOMS? (PLEASE CIRCLE)

RUNNY NOSE ITCHY NOSE STUFFY NOSE ITCHY EYES WATERY EYES FREQUENT SNEEZING

ITCHY MOUTH/ LIPS/ THROAT POST NASAL DRIP (DRAINAGE DOWN BACK OF THE THROAT / CLEARING THROAT)

HOW OFTEN DO YOU EXPERIENCE THESE SYMPTOMS? (PLEASE CHECK OFF)

___ OCCASIONALLY (2-3 TIMES PER YEAR)
___ OVER 3 TIMES PER YEAR
___ A FEW LONG PERIODS OF TIME PER YEAR [SPRING, SUMMER, FALL, WINTER}
___ MOST OF THE YEAR

DO YOU TAKE PRESCRIPTION OR OVER-THE-COUNTER (OTC) MEDICATIONS TO MANAGE YOUR ALERGY SYMPTOMS? YES NO

INDICATE BELOW SYMPTOMS/ CONDITIONS YOU'VE EXPERIENCED DURING THE LAST 1-2 YEARS (PLEASE CHECK OFF)

___ RELATED ISSUES [SINUS PRESSURE, PAIN, HEADACHES; SINUSITIS)
___ REOCCURRING SEASONAL COLDS
___ CHRONIC COLDS [LASTING LONGER THAN 2 MONTHS]
___ MIGRAIN HEADACHES
___ RESTLESS SLEEP/ CHALLENGES SLEEPING THROUGH THE NIGHT/ SNORING
___ CONSISTENT OR REOCCURRING COUGHING
___ FEELING OF FATIGUE, IRRITABILITY AND RESTLESSNESS
___ ASTHMA
___ SKIN CONDITIONS [DRY AND/OR ITCHING SKIN... ETC...)

PATIENT SIGNATURE: _____ DATE: _____