EXPRESSMED URGENT CARE
PATIENT ACKNOWLEDGEMENT FORM
NOTICE OF PRIVACY PRACTICES

Print Patient Name: _____Date:_____

____ I have received a copy of the ExpressMed Urgent Care Notice of Privacy Practices.
____ I was offered a copy of the ExpressMed Urgent Care Notice of Privacy Practices.

Authorization: I, with my signature, authorize ExpressMed Urgent Care, and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. I also authorize ExpressMed Urgent Care, to furnish information to the identified insurance carrier(s) for prior authorization, pre-certification or payment of health care services. This information may include claims, copies of medical information, faxes and phone calls concerning care provided or proposed. I shall assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by the insurance plans, as required by my contract with my insurance plan and state regulation.

I also authorize and give consent to the identified physicians/practice and other health care professionals associated with this physician to discuss my care or other relevant information with attorneys, accountants, malpractice carrier, outside consultants, transcription, billing agents, coding specialists as deemed necessary by my physicians. This includes all services relating to my medical care, including hospital services, nursing home services, lab services, radiology services and care directly ordered by my physician. This contract may include ongoing correspondence with referring and consulting physicians for the duration of your care with them as needed for continuity of care.

I further understand that my health care insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of this contract, I am aware that I may be responsible for all charges that are incurred.

Patient Signature: _____ Date: _____

ExpressMed Urgent Care representative: _____
Representative's Signature: _____ Date: _____

____ A good faith effort was made to provide a copy of the ExpressMed Urgent Care Notice of Privacy Practices to this patient and to obtain his/her acknowledgement of the same.
Patient: ____accepted ____declined the Notice and refused to sign this acknowledgement.

HEALTH HISTORY

(CONFIDENTIAL)

Name _____ **Today's Date** _____

Age _____ **Birthdate** _____ **Family Doctor** _____

Reason for visit: _____

PAST MEDICAL HISTORY - please check all that apply

____ Allergies	____ CAD	____ High Cholesterol
____ Anemia	____ Chrons Disease	____ Irritable Bowl Disease
____ Arthritis	____ Depression	____ Migraine
____ Asthma	____ Diabetes (type ____)	____ Osteoporosis
____ Blood clots	____ GERD	____ Renal Disease
____ Cancer	____ Hepatitis	____ Seizure Disorder
____ COPD	____ High Blood Pressure	____ Thyroid Disease

Other _____

FAMILY MEDICAL HISTORY - please check all that apply

____ Allergies	____ CAD	____ High Cholesterol
____ Anemia	____ Chrons Disease	____ Irritable Bowl Disease
____ Arthritis	____ Depression	____ Migraine
____ Asthma	____ Diabetes (type ____)	____ Osteoporosis
____ Blood clots	____ GERD	____ Renal Disease
____ Cancer	____ Hepatitis	____ Seizure Disorder
____ COPD	____ High Blood Pressure	____ Thyroid Disease

Other _____

WOMEN ONLY

Last menstrual period: _____

Are you currently pregnant? _____

MEDICATIONS: List medications you are currently taking.

Pharmacy Name **Phone**

ALLERGIES: To medications or other

SURGERIES:

SOCIAL HISTORY: Caffeine ( ) Yes ( ) No Alcohol ( ) Yes ( ) No Tobacco ( ) Yes ( ) No

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature Date