Urgent Care Clinic of Oxford

*** PLEASE PRINT! ***

PAYMENT IS DUE AT THE TIME OF SERVICE!

Print Patient Full Name_____

Mailing Address_____ Apt #._____

City_____ State_____ Zip_____

Telephone: Home (___) _____ Cell (___) _____ Work (___) _____

Date of Birth_____ Please **Circle** Marital Status: Single Married Divorced Widowed

Social Security # _____ Sex: M___ F____ Age: _____

Email Address_____

Please **Circle** Race: Am Indian Black White Asian Hispanic Other Refuse to report

Please **Circle** Ethnicity: Hispanic or Latino Non-Hispanic Refuse to Report

Primary Language_____

Employer_____ Address: _____Number:_____

Pharmacy Name _____ Town: _____

Spouse Name: _____ Date of Birth: _____ Sex: M___ F_____

Spouse's Home Phone (___) _____ Cell Phone (___) _____

Emergency Contact: _____ Number (___) _____ Relationship: _____

NAME OF PERSON WHO CARRIES THE INSURANCE

Name: _____ Relationship to patient: _____

Date of Birth: _____ SSN#_____

Phone: Home (_____) _____ Cell: (_____) _____

Address: _____ Apt. #____City_____ State_____ Zip_____

PLEASE INITIAL ALL LINES TO SHOW YOU HAVE READ STATEMENTS:

Please allow the receptionist to copy your insurance card and driver's license. _____Patient's Initials

Please alert the receptionist if the visit is due to injury or car accident. _____ Patient's Initials

Work related injuries must be approved prior to seeing the doctor. _____Patient's Initials

Regardless of coverage, you are responsible for payment if not paid by carrier. _____ Patient's Initials

Tricare Select: We will file the claim for you. We do not accept TRICARE PRIME. _____ Patient's Initials

PATIENT RECORD OF DISCLOSURE

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications o that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Please select **ALL** that apply but **AT LEAST ONE** option for each category to indicate your preferences for communication.

Home/Cell Telephone _____

_____ O.K. to leave message with detailed information
_____ Leave message with call back number only
_____ Do not leave message at all.

Work Telephone _____

_____ O.K. to leave message with detailed information
_____ Leave message with call back number only
_____ Do not leave message at all.

Written Communication

_____ O.K. to mail to my home address
_____ O.K. to mail to my work/office address
_____ O.K. to fax to this number _____

Any other preferred method of communication _____

_____

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate

CONSENT FOR PURPOSE OR TREATMENT

I consent to the use or disclosure of my protected health information by Urgent Care Clinic of Oxford for the purpose of Diagnosing or providing treatment to me, obtaining payment for my health bills or to conduct health care operations of Urgent Care Clinic of Oxford. I authorize the physicians(s) of the clinic to give reasonable and proper medical care by today's standards of care. I understand that diagnosis or treatment of me by the physician(s) of Urgent Care Clinic may be conditioned upon my consent as evidenced by my signature on this document.

SIGNATURE_____

ASSIGNMENT OF BENEFITS

I hereby assign, transfer and set over to Urgent Care Clinic of Oxford, the physician(s) of Urgent Care Clinic, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I understand that this order does not relieve me of my obligations to pay such bills if not paid by my Insurance Company, or any balance due after payments by my Insurance Company. Failure to respond to requests for information needed by insurance will result in no future claims filed by above provider. In the event I fail to pay any charges and the account is turned over to a collection agency or an attorney, I agree to pay all collection costs incurred, including, but not limited to, a collection fee, reasonable attorney's fees and court costs. Tricare Select cardholders pay 15% over Tricare Select allowable fees.

SIGNATURE_____

RESTRICTIONS

I understand I have the right to request a restriction as to how my Protected Health Information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Urgent Care Clinic of Oxford is not required to agree with the restrictions that I may request. However, if Urgent Care Clinic of Oxford agrees to a restriction that I request, the restriction is binding on Urgent Care Clinic of Oxford and the physician(s) of Urgent Care Clinic.

SIGNATURE_____

RIGHT TO REVOKE CONSENT AND RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have the right to revoke this consent, in writing, at any time, except to the extent that the physician(s) of Urgent Care Clinic of Oxford or Urgent Care Clinic of Oxford has taken action in reliance on this consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may apply to me.

I have received a copy of Urgent Care Clinic of Oxford's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills, or in the performance of health care operations of the Urgent Care Clinic of Oxford. The Notice of Privacy Practices is also posted in the waiting room. The Notice of Privacy Practices also describes my rights and Urgent Care Clinic of Oxford's duties with respect to my protected health information.

Urgent Care Clinic of Oxford reserves the right to change the privacy practices that are described in the Notice of Privacy Practices I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next visit.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

_____

Witness

THIS IS OPTIONAL ONLY

We understand that convenience is not often associated with today's healthcare environment. Our practice not only focuses on excellent healthcare service but also how to provide service as cost and time effectively as possible. We have found that collecting all known liability at the time of service is not only beneficial for the practice, but experience has proven that our patients appreciate knowing they will not have to worry about delayed billing or payments.

We provide secured methods of accepting your payment at the time of treatment and also for keeping your credit card on file to handle any remaining balance after insurance company reimbursement.

We will also work with you in establishing a payment schedule if necessary using this credit card authorization form.

I _____

Authorize Urgent Care Clinic of Oxford, LLC

To keep my signature and credit card information on file and to charge my account for balances that remain unpaid.

I understand the provider is offering this as a courtesy and I may pay my balance in full at any time and cancel this agreement. I am authorizing the use of this card for all unpaid balances due to Urgent Care Clinic of Oxford, LLC.

Patient Name :_____

Card Holder Name:_____

Card Holder Address: _____

Type of Credit Card: _____#:_____

Expiration Date:_____Security Code:_____

Signature:_____Date: _____

MEDICAL RELEASE DISCLOSURE

In addition to the use and disclosure of your medical information stated in the notice of Privacy Practices for Protected Health Information, I hereby give permission for the following individuals to receive my medical information without further permission from me. In order for the following individuals to receive the requested information they must identify themselves by name and provide my date of birth upon request by Urgent Care staff.

Name:	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

None: _____

_____
Signature/Patient or Responsible Party

_____
Date

*** To revoke or change the above authorizations, Please contact us: ***

Urgent Care Clinic of Oxford
1487 Belk Blvd
Oxford, MS 38655

Phone: 662-234-1090 Fax: 662-234-0432