CRESTVIEW URGENT CARE
2400 S FERDON BLVD, STE A
CRESTVIEW, FL 32536

URGENT CARE
Care at Your Convenience

PHONE: 1-850-398-8668
FAX: 1-850-398-8679
EMAIL: CUC@MYLOCALURGENTCARE.NET

Patient's Name: _____ Today's Date: _____

Date of Birth: _____ Sex: _____ Marital Status: _____

Employment Status: _____ Employer Name: _____

Do you reside in an assisted living facility? o Yes o No Do you live alone? o Yes o No

This sheet must be filled out COMPLETELY for every visit. ☺

Reason for today's visit (please include **SYMPTOMS**):

_____

_____

_____

_____

How long have you been experiencing today's complaint? _____

Have you ever had this complaint before? o Yes o No If yes, when? _____

List all known **MEDICATION ALLERGIES**:

_____

_____

If you do not have any medication allergies, please check here: ☐

List of current **MEDICATION** (must include dosage and frequency):
IF YOU DO NOT KNOW PLEASE **CONTACT YOUR PHARMACY**

_____

_____

_____

_____

_____

_____

_____

If you do not take any prescribed medication please check here: ☐

Are your immunizations up to date? o Yes o No

	YES	NO
Do you currently smoke?		
Have you smoked in the past? *(No if smoked less than 100 cigarettes in lifetime)*		
Do you currently chew tobacco?		
Have you chewed in the past?		
Do you drink alcohol, beer, or wine?		
Any recreational drug usage?		

If you marked yes to any question above, please explain and list frequency of use (per day/week):

_____

_____

Females: When was the first day of your last menstrual period? __/__/____

Are you currently pregnant? o Yes o No If **PREGNANT,** how many weeks? _____

Are you currently breastfeeding? o Yes o No

FLIP OVER

PLEASE FILL OUT COMPLETELY

Patient's Address: _____

City: _____ State: _____ Zip: _____

Home: (____) _____ Work: (____) _____ Cell: (____) _____

Pharmacy for today: _____ City of Pharmacy: _____

**We now have available for Work Comp patients ONLY a by mail pharmacy that will send the medications prescribed to your house the next day after your visit. Please let us know if you would like to use this pharmacy (IWP).

AUTHORIZATION TO TREAT

I understand that this authorization includes my consent for medical tests, procedures, drugs and other services and supplies as considered advisable. This treatment may include, but is not necessarily limited to, anesthesia, pathology, radiology and other imaging and diagnostic services, and other special tests and services including tests for communicable diseases and toxins, as ordered by the physician responsible for my care during my visit. I acknowledge that the practice of medicine is not an exact science and no guarantees or promises have been made to me as to the results of examination, care, or treatment. I acknowledge that it is important for me to provide accurate and complete information regarding my symptoms, medications, drug use, and other information, and that failure to do so can adversely impact my care.

Some insurance companies require pre-authorization services. If I am required to obtain an authorization for today's visit and have not done so, I agree to assume all financial responsibility. If I receive any additional services from specialists, hospitals, or other healthcare providers in connection with, or as a result of this visit, those charges may also be my responsibility, unless preauthorized as required by my insurance company. I authorize the release of medical or other information to my insurance company, the Center for Medicare and Medicaid Services, or its carriers as necessary to determine payment for these or related services. Certain lab tests may be sent to an independent lab for processing. I understand I may receive a separate bill for these services. In the event that collection procedures are initiated on any outstanding balance, I agree to be responsible for the costs of collection including, but not limited to: court costs, expenses, and attorney fees, to the extent permitted by law. I understand that the foregoing provision applies equally to myself or any individual for whom I am authorizing treatment.

ASSIGNMENT OF BENEFITS

The undersigned patient hereby assigns the benefits of insurance under the applicable health/automobile insurance policy to **Crestview Urgent Care, Inc.** and all locations for services rendered to the undersigned patient and covered by health insurance, PIP coverage, and/or Medical Payments coverage. This is a direct assignment of my rights, causes of action, and benefits under the applicable automobile insurance policy. The undersigned further agrees to pay any applicable deductible or co-payment not covered by Auto Insurance or Medical Payments Coverage.

CONSENT FOR RELEASE OF HEALTH/MEDICAL INFORMATION

I hereby acknowledge I am providing this authorization to representatives of Crestview Urgent Care.

I hereby give my consent to use and disclose protected health information (PHI) about me to carry out treatment or payment health care operations (TPO). I have the right to review the Notice of Privacy Practices prior to signing this consent. All rights are reserved to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request.

With is consent, representatives may call my home or other alterative location and leave a message on voice mail or in person in reference to any items that assist in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, representatives may mail to my home or other alternative location any items that assist in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

I have the right to request restrictions regarding how it uses or discloses my PHI to carry out TPO. The Center is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke it, treatment may be declined.

Patient or Guardian/Parent Signature: _____ **Date:** _____