41715 Winchester Road Ste. 101, Temecula, CA 92590
Ph: 951.308.4451 | Fax: 951.506.0992
www.temecula24hoururgentcare.com

Carlsbad
Urgent Care
We're here when you need us.

2804 Roosevelt Street, Carlsbad, CA 92008
Ph: 760.720.2804 | Fax: 760.720.7400
www.carlsbadurgentcare.com

295 S. Rancho Santa Fe Road, San Marcos, CA 92078
Ph: 760.471.1111 | Fax: 760.471.1001
www.sanmarcos.care

Medical Questionnaire

Patient Name: ________________ (Last) , ________________ (First) **Date of Birth:** _____/_____/______ **SSN:** ____-____-______

Home Phone Number: _____ - _____ - ________ **Cell Phone Number:** _____ - _____ - ________

Reason for today's visit: ____

Duration of symptoms: ______________________ **Did this injury happen at work?** **YES** **NO**

NOTE: **If you are here *only* for a Dept. of Transportation drug or alcohol screening, the below section is optional.**

YES	NO		YES	NO		YES	NO	
		Chest Pain / Pressure			Fainting Spells/ Loss of consciousness			Difficulty Breathing
		Painful Urination			Cough			Frequent Urination
		Head Injury			Fever			Change in Urine Color
		Rash			Unintended Weight Loss/Gain 20 lbs in 6 months			Chronic or Recurrent Back Pain
		Eye Pain			Irregular Heartbeat			Pain in Joints
		Blurry Vision			Abdominal Pain			Muscle Pain
		Double Vision			Heartburn / GERD			Muscle Weakness
		Ear Pain / Pressure			Nausea			Headache
		Recent Decreased Hearing			Vomiting			Lightheadedness
		Loss of Appetite			Diarrhea			Dizziness
		Painful Breathing			Constipation			Numbness / Tingling
		Abnormal Breathing Sounds / Wheezing			Bloody or Black Stool			Excessive Thirst and Urination

Carlsbad
San Marcos
Temecula

Check if any of your information has changed:

New Address New Phone Number New Insurance

Clinic Visiting:

Temecula 24 Hr. Urgent Care Carlsbad Urgent Care San Marcos Urgent Care

Initials:__________

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Please *initial* the following spaces if you have read and understand the following policies and have been offered copies of these policies:

______ Member Eligibility/Covered California Waiver

______ Financial Policy

______ HMO/Self Pay Waiver

Print Patient Name: ____________________ (*First*) ______________________ (*Last*) **Relationship:** *(if other than patient)* __________________

Signature of patient or guardian ____ **Date:** _____ /_____ /______

Emergency Contact Name : ____ **Relationship to patient:** ______________________

Emergency Contact's Date of Birth: _____ /_____ /______ **Emergency Contact Phone:** _____ - _____ - ________

Authorization/consent

I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgement of the medical provider. I hereby authorize the medical provider to release any information acquired in the course of my examination or treatment as needed for payments or authorizations for tests, procedures, referrals or any other services deemed medically necessary. I hereby authorize payment directly to the medical provider, of benefits otherwise payable to me, for service rendered.

Print name *(patient or guardian)*: __________________ (*First*) __________________ (*Last*) **Relationship:** *(if other than patient)* __________________

Signature of patient or guardian ____ **Date:** _____ /______ /______

Authorization to Release Medical Information:

<u>**Release Records To:**</u>

Name: ____ Phone: _____ - _____ - ________ Fax: _____ - _____ - ________

Address: ______________________________________ City: ___________________ State: _________ Zip: _________________

HIPAA AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION:

I voluntarily, authorize the above Releasing Entity to use and disclose my health information.

Print Name: (patient or guardian) __________________________________ **Relationship** (if other than patient) _____________

Signature of patient or guardian ____ **Date:** _____ /______ /______

Notice of Privacy Practices

As required by the privacy regulations created as a result of the health insurance Portability and Accountability Act of 1996(HIPPA)

This notice describes how health information about you (as a patient of this practice) may be used and disclose and how you can get access to your individually identifiable health information. Please review this notice carefully.

A. Our commitment to your privacy: Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following important information:
How we may use and disclose you're PHI, Your privacy rights in your PHI, Our obligations concerning the use and disclosure of your PHI. The terms of this notice apply to all records containing your PHI that are created or retained by our practice, We reserve the rights to revise or amend this notice of Privacy practices. Any revision or amendment of this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current notice in our offices in a visible location at all times, and you may request a copy of our most current notice at any time.

B. If you have any questions, please contact Temecula 24 Hour urgent care 41715 Winchester road suite 101Temecula CA 92591.

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment: Our practice may use your PHI to treat you, For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice including, but not limited to, our doctors and nurses- may use of disclose your PHI in order to treat you or to assist others In your treatment .Additionally , We may disclose your PHI to others who may assist in your care, such as your spouse, children or parents . Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.
2. Payment: Our practice may use and disclose your PHI in order to bill and collect payments for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and other entities to assist in billing and collection efforts.
3. Health care operations: Our practice may use and disclose your PHI to operate our business. As examples, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activates for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.
4. Appointment reminders: Our practice may use and disclose your PHI to contact you and remind you of appointment's
5. Treatment options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
6. Health- related benefits and services: our practice may use and disclose your PHI to inform you of your health-related benefits or services that may be of interest to you.
7. Release of information to family/friends: our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the practice for treatment of cold symptoms. In this example, the baby sitter may have access to this child's medical information.
8. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law. D. use and disclose of your PHI in certain special circumstances:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information.

1. Public health risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purposes of: -Maintaining vital records, such as births or deaths, Reporting child abuse or neglect, Preventing or controlling disease, injury or disability, Notifying a person regarding potential exposure to communicable disease, reporting reactions to drugs or problems with products or devices, Notifying individuals if a product or device they may be using has been recalled, Notifying the appropriate government agency(ies) and authority (ies) regarding the potential abuse of neglect of an adult patient (including domestic violence); However we will only disclose the information if the patient agrees or we are required or authorized by law to disclose this information. Notifying your employer under limited circumstances related primarily to the workplace injury or illness or medical surveillance.
2. Health oversight activities: Our practice may disclose your PHI. To a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general. Lawsuits and similar proceedings: Our practice may use and disclose your PHI in response to a court or administrative order. If you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response

to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested

3. Law enforcement: we may release PHI if asked to do so by a law enforcement official: Regarding a crime victim in certain situations, if we are unable to obtain the persons agreement. Concerning a death we believe has resulted from criminal conduct, regarding criminal conduct at our practice. In response to a warrant, summons, court order, subpoena or simple legal process, in an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator).

4. Serious threats to health or safety: our practice may use and disclose your PHI when necessary to reduce or prevent serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

5. Military: Our practice may disclose your PHI if you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

6. National Security: Our practice may disclose your PHI to federal official for intelligence and national security activities authorized by law. We also may disclosed your PHI to federal and national security activities authorized by law, We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

7. Inmates: Our Practice may disclose you PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety of the health and safety of other individuals.

8. Workers Compensation: Our practice may release your PHI for workers compensation claims and similar programs. E. Your rights regarding your PHI:

You have the following rights regarding your PHI that we maintain on you:

1. Confidential communication: you have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For example, you may ask that we contact you at home, rather that work. In order to request a type of confidential communication, you must make a written request to Temecula 24 Hour urgent care 41715 Winchester road suite 101Temecula CA 92591 Specifying the requested method of contact, or location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, Payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for our care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request to request a restriction in our disclosure of your PHI, you must make your request in writing to Temecula 24 Hour urgent care 41715 Winchester road suite 101Temecula CA 92591.Your request must describe in a clear and concise fashion: The information you wish restricted, Whether you are requesting to limit our practice's use, disclosure or both, To whom you want the limits to apply.

3. Inspection and copies: you have the right to inspect and obtain a copy of your PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Temecula 24 Hour urgent care 41715 Winchester road suite 101Temecula CA 92591in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in a certain limited circumstances; however, you may request a review of your denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment: You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by of for our practice .To request an amendment, your request must be made in writing and submitted to Temecula 24 Hour urgent care 41715 Winchester road suite 101Temecula CA 92591. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask to amend information that is in our opinion: (a) Accurate and complete (b)not part of PHI kept by or for our practice, (c) not part of the PHI which you would be permitted to inspect and copy, or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5: Accounting of disclosures: All of our patients have the right to request an "accounting of disclosures.' This is a list of certain non- routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as a part of the routine patient care in our practice is not required to be individually documented. For example, the doctor is sharing your information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Temecula 24 Hour urgent care 41715 Winchester road suite 101Temecula CA 92590. All requests for "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12 month period is free of charge, but our practice may charge you for additional lists within the same 12 month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a paper copy of this notice: You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice contact Temecula 24 Hour urgent care 41715 Winchester road suite 101Temecula CA 92591.

7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the secretary of the department of health and human services. To file a complaint with our practice, contact, Temecula 24 Hour urgent care 41715 Winchester road suite 101Temecula CA 92591. All complaints must be submitted in writing. You will not be penalized for filling s complaint.

8. Right to provide an authorization for other uses and disclosures: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: we are required to retain records of your care.

If you have any questions regarding this notice of your health information privacy policies, please contact Temecula 24 Hour urgent care 41715 Winchester road suite 101Temecula CA 92590.

Our Financial Policy

WE ARE DEDICATED TO PROVIDING THE BEST POSSIBLE CARE FOR YOU. WE WANT YOU TO COMPLETELY UNDERSTAND OUR FINANCIAL POLICIES. Payment is due at the time of service unless arrangements have been made in advance. Cash, checks from California based banks, and credit cards are accepted. Please keep in mind that your insurance policy is contracted between you and your insurance company. As a service to you, we will file your insurance claims if you assign the benefits to us- in other words, you agree to have your insurance company pay the medical provider directly. If your insurance company does not pay this practice within a reasonable period, we will have to look to you for payment. We have contracts with many insurance companies and other health plans to accept assignment of benefits. We will bill the insurance; however you are required to pay your deductible and/or co-payments at the time of service. Not all insurance plans cover all services. In the event that your insurance plan determines a service "not covered", you will be responsible for your complete charge. Payment is due upon receipt of statement from our billing office. There is a possibility of additional charges for afterhours care. I have read and understand the practice's financial policy and I agree to be bound by its term. I also understand and agree that such terms may be amended by the practice upon annual review and it is my responsibility to ask for the updates.

Member Eligibility Wavier

We make every effort to verify your insurance benefits at the time of your visit, there are times when verification is just not possible. In order to provide the best care possible, we will collect the co-pay listed on your card or an estimated co-insurance from you now and submit the claim to your insurance company for you. We will provide the insurance company with all of the information they need to process you claim, however, if for any reason the claim is unpaid by your insurance company, you will be responsible for the amount due and will receive a bill from us. I understand my possible financial responsibility for services rendered.

Covered California Waiver

We have attempted to participate in Covered California, but unfortunately we are still not a contracted provider. We will continue to beseech them so was can be a part of the Covered California Network; but until then, we will collect $85.00 copay at the time of service. We will bill your insurance as a courtesy, often if you actively assist us in getting Covered California to pay they will. If your insurance company pays we can send you a refund. We fully understand these are tough times and we are working diligently to get you first and foremost outstanding medical care. We are trying not to make this an undue financial burden.

HMO Waiver

In order to provide you with the best possible care, we will attempt to bill your insurance for this urgent matter. We will provide your insurance with all the information we can in order to process the claim. If for any reason the claim or any portion of the claim is unpaid, you are responsible for the amount due and will receive a bill from us.

Self-Pay Agreement

Welcome to our clinic, where our professional staff are committed to providing you with the highest quality medical services. You have registered as a SELF-PAY patient. This means that at the time of service you will be paying by cash, check, or credit card in full at the time of service. You are being offered a discount on services rendered in lieu of us billing any insurance (if applicable). We will not bill insurance for services provided under this arrangement. No forms will be produced now, or in the future, for any insurance billing. The following is a statement of our Self-Pay Financial Policy, which we require you to read and initial prior to receiving our treatment. I fully understand that in addition to the office visit charge today, there may be additional charges for labs, x-rays, immunizations, tests, etc. that will be due prior to treatment. I declare that I do not have medical insurance or I release my rights to bill insurance for this visit. I understand that I am financially liable for all services provided to me, my dependents or any other person for which I have assumed responsibility. I understand my possible financial responsibility for the services rendered.

As acknowledgement and understanding of the above I have initialed the intake form provided.