HIPAA Information and Consent Form

Health Portability and Accountability Act (HIPAA)

SouthStar Urgent Care is committed to maintaining the integrity of your protected health information and complies with all applicable state and federal regulations. The federal privacy regulations of the Health Portability and Accountability Act (HIPAA) took effect April 14, 2003. In support of our policy to comply with the HIPAA notice of privacy rights, we are obligated under federal regulations to ask you to sign an acknowledgement of the HIPAA privacy notice being made available to you. A full and detailed copy of our HIPAA policies and regulations are available upon request.

I acknowledge receipt of the notice of privacy rights with detailed information about how SouthStar Urgent Care may use and disclose my protected health information. I understand that SouthStar Urgent Care reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

I, ____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM, and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature: ____ **Date:** ___________________

Relationship to Patient (please circle one): Self Parent Legal Guardian

Consent for Medical Treatment

Thank you for choosing SouthStar Urgent Care as your healthcare provider. We are committed to providing quality medical care. We ask that you read, sign and return this form to us prior to your treatment. Payment is required at the time of service and may be in the form of cash, debit card, or personal check. Patient or Patient's legal representative agrees to the following terms of treatment: I, the patient or authorized representative, consent to any examination, evaluation and treatment regarding my illness, injury or other health concern affecting me at any time I present at SouthStar Urgent Care clinics for care. These services may include, but not limited to, laboratory procedures, x-ray examinations, and medical or surgical treatment or procedures. I agree to lab testing if a SouthStar Urgent Care team member encounters a blood or a body fluid exposure from me while receiving services within a SouthStar Urgent Care clinic. My personal information will be updated at the time of each visit to SouthStar Urgent Care clinics. I am a patient, the parent of a minor child, or the legally authorized representative of the patient and I authorize SouthStar Urgent Care clinics to submit a claim on my behalf. I understand that I am financially responsible for any non-covered service. I have read and understand this treatment agreement.

I, ____ do hereby consent and acknowledge my agreement to the terms set forth in the SOUTHSTAR URGENT CARE CONSENT FOR MEDICAL TREATMENT FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature: ____ **Date:** ___________________

Relationship to Patient (please circle one): Self Parent Legal Guardian

Patient Registration

How did you hear about SouthStar Urgent Care Urgent Care Clinic?

□ Clinic Sign □ Online/Google □ Referred by Friend/Family/CoWorker
□ Newspaper □ Billboard □ Referred by Insurance/Provider

Patient FULL Name:____
Social Security #:______________________________ Date of Birth:_____/_____/____
Gender: □ Male □ Female

Contact Information:

Street Address: ____
City:_________________________________ State:________ Zip:__________________
^Home Phone: _____________________________________ Preferred Contact Method:
^Mobile Phone: ____________________________________ □ Home □ Mobile □ Email
*E-Mail: ____

Patient Emergency Contact

Contact Name: ____
Relationship to Patient: _________________ Phone Number: _______________________
Please check one: SouthStar Urgent Care has my permission to release my medical information to my emergency contact □ Yes or □ No ****Please Initial here: _______**

Optional Information:

Employer Name: ________________________________ *Phone:* ______________________
Insurance Carrier: ______________________________ *Marital Status:* ________________
Insurance Guarantor: _____________________________ *Guarantor Birthdate:* ___________
Primary Care Physician: ___________________________ *Race:* ______________________
Preferred Language: ______________________________ *Ethnicity:* ____________________

Contact Consent Information

*You expressly consent and agree that, in order to discuss or service your accounts(s) (the "Accounts ") or to collect amounts you may owe, SouthStar Urgent Care, and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively, "We") may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that we may also contact you by sending text messages, emails, using any e-mail address you provide to us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

^Submitting your email address on this form will automatically enroll you into our clinic informational email list.

Patient Medical History

Patient:________________________________ Date of Birth:____________________

Do you wear glasses or contacts? ❑ Yes ❑No Date of last Tetanus shot: _____________

Allergies to Medications: ❑ No Allergies to Medication

Medication Names

________________________ ________________________ ________________________

________________________ ________________________ ________________________

________________________ ________________________ ________________________

________________________ ________________________ ________________________

Current Medications (prescribed and Over the Counter):

❑ No Medications

________________________ ________________________ ________________________

________________________ ________________________ ________________________

________________________ ________________________ ________________________

________________________ ________________________ ________________________

Medical History: Check box if you have ever had any of the following:

❑ No Medical History

❑ ADD/ADHD
❑ Asthma
❑ A-Fib
❑ Anxiety
❑ Arthritis
❑ Glaucoma
❑ Cancer
❑ COPD
❑ Cirrhosis
❑ Clotting Disorder
❑ Diabetes
❑ Depression

❑ Epilepsy
❑ Hepatitis
❑ High Blood Pressure
❑ High Cholesterol
❑ HIV positive/AIDS
❑ Kidney Disease
❑ Thyroid Disease
❑ Tuberculosis

❑ Other – Please List Below

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Initial

Surgical History: ❑ No Surgical History

Head/Neck/Breast Surgery

- ❑Adenoidectomy
- ❑Tonsillectomy
- ❑Ear Tubes
- ❑Mastectomy
- ❑Cataract surgery

Heart/Lung Surgery

- ❑Coronary Bypass
- ❑Cardiac Catheterization
- ❑Heart valve replacement
- ❑Lung Cancer

Abdominal/Pelvic Surgery

- ❑Appendectomy
- ❑Gastric band
- ❑Gall Bladder removal
- ❑Gastric Bypass
- ❑Hernia
- ❑C-section
- ❑Tubal ligation
- ❑D & C
- ❑Endometrial ablation
- ❑Hysterectomy

Bone/Joint/Spine

❑Joint Relacement Specify Type:

❑Joint Repair Specify Type:

❑Spine surgery Specify Type:

Other Surgeries

List: ______________________________

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____

Social History:

Do you smoke?

❑Current ______ PPD ❑Former (Date Quit ____________) ❑Nonsmoker ❑Secondhand Smoke

Do you drink alcohol? ❑YES❑NO

If yes, ❑Rare ❑Occasional ❑Everyday

Have you ever used illegal drugs? ❑YES ❑NO If so, what drugs?

____

Family History: ❑ No Family History

	Diabetes	High Blood Pressure	Heart Disease	High Cholesterol	Cancer	Other (please list)
Father	❑	❑	❑	❑	❑	
Mother	❑	❑	❑	❑	❑	
Other_______________	❑	❑	❑	❑	❑	

Sign:____ Date:__________________

Print:____

From # 031

Initial