UNIVERSITY URGENT CARE

2628 W. CHARLESTON BLVD. LAS VEGAS, NV 89102
P: (702) 644-0500 F: (702) 258-0566

PATIENT NAME:____ **BIRTH DATE:**__________________ **SEX:** ☐ **Female** ☐ **Male**
LAST/FIRST/MIDDLE INITIAL

HOME:(_______**)**_________**-**___________ **CELL PHONE: (**_______**)**_______**-**__________ **MESG:(**_______**)**________**-**____________

PATIENTADDRESS:____**Apartment_#**___________________________________
ZIP CODE

REFERRING DOCTOR:____
NAME ADDRESS PHONE

SOCIAL SECURITY #:__________**-**________**-**________**LIC. #:**______________________ **Marital Status**: ☐ Single ☐ Married ☐ Divorced

EMPLOYED BY:____
NAME ADDRESS

WORK PHONE#: (________**)**________**-**____________ **PATIENT OCCUPATION:**____

SPOUSE NAME:____ **PHONE: (**_______**)**________**-**_____________

EMERGENCY CONTACT:____ **PHONE: (**_______**)**________**-**_____________

PRIMARY INSURANCE:______________________________________**ID #:**____________________________**Group #:**_________________

PRIMARY CARD HOLDER:____
NAME BIRTH DATE SSN #

SECONARY INSURANCE:____________________________________**ID #:**_____________________________**Group #:**________________

PRIMARY CARD HOLDER:____
NAME BIRTHDATE SSN #

ARE YOU BEING TREATED FOR AN AUTOMOBILE ACCIDENT OR PERSONAL INJURY? YES / NO

CIRCLE ONE: WORK RELATED INJURY / PERSONAL INJURY / AUTO ACCIDENT

DATE OF INJURY:______________________________ **INJURED BODY PART(S):**____

DO YOU HAVE MED PAY INSURANCE (Medical benefit through your auto insurance)? YES / NO

INSURANCE CARRIER:______________________________**CLAIM #:**____________________________ **PHONE #:**______________________

DO YOU HAVE AN ATTORNEY? YES / NO NAME:_______________________________________ **PHONE #:** ________________________

I AM AWARE SPECIAL REPORTING IS REQUIRED TO ASSIST MY ATTORNEY WITH MY PERSONAL INJURY CASE AND A FEE IS ASSOCIATED WITH THIS SERVICE. I AM REQUESTING THAT SPECIAL REPORTS ARE PREPARED AND FORWARDED TO MY ATTORNEY. ____
PATIENT INITIALS

ASSIGNMENT AND RELEASE

I authorize payment of medical benefits to be made directly to *Radar Medical Group, LLP dba University Urgent Care,* for services rendered. I authorize any insurance company, employer, physician to release any information to this claim and the expenses be reported. I hereby authorize the doctor to release all information necessary to secure the payment of benefits and/or further medical treatments. I authorize the use of this signature on all my insurance submissions whether manual or electronic. Services that are rendered, not covered by insurance, will be my responsibility.

Date:__________________________ **Signature:**____

"Our policy requires us to bill your health insurance for services rendered during your course of treatment unless you specifically instruct us otherwise. Therefore, if you do not want Radar Medical Group to bill your insurance, you must sign below instructing us NOT to bill your insurance. By instructing Radar Medical Group not to bill your insurance, you acknowledge that you will be responsible for the usual and customary fees for services that are rendered to you during your treatment. Further, by instructing us not to bill your insurance, you understand that a later request to bill insurance during your course of treatment may be denied".

Date:__________________________ **Signature:**____

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NARCOTIC/CONTROLLED SUBSTANCE PRESCRIBING POLICY

Please be advised of the following:

We do not refill narcotic/controlled substance on the first visit.

We reserved the right not to prescribed narcotic/controlled substance on the first visit. The patient is responsible for providing University Urgent/Primary Care with appropriate documents that assist physician diagnosis and treatment of his/her condition.

As a primary care physician we do not manage pain chronically thus chronic pain patient will be referred to pain management physician for further care.

I understand and agree with the above notice.

X____ ________________________

Patient Signature Date

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS IN ACCORDANCE TO HIPAA

I ____, understand that as a part of my healthcare, Radar Medical Group LLP dba University Urgent Care originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer(s) can verify that service billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges.

- The right to review the notice prior to signing this consent/disclosure
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

I understand that Radar Medical Group, LLP Dba University Urgent Care is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me permitted by Section 164.520 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment or healthcare operation, it may become necessary to disclose my protected health information to another entity (Insurance Company, referring physician, consulting physician, hospital, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax or email.

In addition, I also give consent to Radar Medical Group LLP dba University Urgent Care to disclose my protected healthcare information to the following person and/or people:

______________________________ ______________________________
Name Relationship

______________________________ ______________________________
Name Relationship

______________________________ ______________________________
Name Relationship

I fully understand and accept the terms of this consent.

X ______________________________ ______________________________
Patient and/or Legal Guardian Date

RELEASE OF INFORMATION AUTHORIZATION

Section A: Must be completed by patient or Patient's representative for all authorizations.

Patient Name:____ **Date of Birth:**________________________

Social Security #:______________________________

I, hereby authorize ____
(Please print name of physician, healthcare provider, facility/hospital)

to release my personal health and medical information as described below to the following person(s) or healthcare provider(s):Name of Dr./Facility :____

Address:____

Office #:____ Contact person:_____________________

Information to be disclosed:

☐ Complete Health Records ☐ Progress Notes ☐ Consultation Reports

☐ Discharge Summary ☐ Laboratory Tests ☐ X-ray Reports

☐ History & Physical examination ☐ Other:____________________________________

For the following period(s) of healthcare:

Date From: _______________________________________ Date To: ____________________________________

Date From: _______________________________________ Date To: ____________________________________

I understand that this will include information relating to (check if applicable):

☐ Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV)

Separate authorization forms are available for disclosure of information relating behavioral health services/psychiatric care and diagnosis/treatment for alcohol and/or drug abuse.

The patient or the patient's representative must read and initial the following statements:

Initial______a. I understand that this authorization is voluntary. I understand that I may refuse this authorization that my refusal to sign will not affect my ability to obtain treatment or payment or m eligibility for benefits.

Initial______b. I understand that I may inspect or receive a copy of the information described on this form if I ask for it and that I will receive a copy of this form after I sign form.

Initial______c. Unless otherwise cancelled, I understand that is authorization will expire on the following, date, event or condition: ____.

Initial______d. I understand that I may cancel this authorization at any time by notifying the providing healthcare provider in writing, but if I do, it won't have any effect on actions taken prior to receipt of the cancellation.

Initial______e. I understand that if the person or entity that receives the above information is not a health care provider or a health plan covered by federal policy regulations, the released information may be disclosed by such person or entity and will likely no longer be protected by the federal policy regulations. The recipient may otherwise be prohibited under federal law from disclosing substance above information, AIDS/HIV status, or mental health information unless another authorization is obtained from me or my representative or unless such use or disclosure is specifically required or permitted by law.

RELEASE OF INFORMATION AUTHORIZATION

Section B: This section must be completed ONLY if a health plan or health care provider has requested the authorization; the requesting party must complete this section.

1. The health plan or health care provider must complete the following

   a. What is the purpose of the use or disclosure? ____

   ____.

   b. Will the health plan or health care provider requesting the authorization receive financial or in kind compensation in exchange for using or disclosing the health information described above?

   Yes or No

X____ ______________________
Signature of patient/parent/guardian/patient representative Date

If signed by other than patient, indicate relationship: ____

Printed name of patient's representative: ____

____ _________________________
Witness signature Date

____ _________________________
Signature of M.D. or representative Date