Only Choice Urgent Care

New Patient Intake

Date _____

Patient Information

Name: First _____ Last _____ MI _____ DOB_____

Mailing Address: _____ City _____ State _____ Zip _____

Sex: _____Male _____Female Marital Status: _____Married _____Single _____ Divorced _____Widowed

SS # _____ Email address _____

Home Phone _____ Cell _____ Other _____

Race: _____ Ethnicity (circle one): Hispanic or Latino/ Non Hispanic or Latino/ Other/ Prefer not to answer

Employer _____ Work Phone _____ Student: Full/Part Time

For Minor:

Parent/Legal Guardian _____ Phone _____ Address _____

Emergency Contact:

Name _____ Phone # _____ Relationship _____

Name _____ Phone # _____ Relationship _____

Preferred Pharmacy: Name _____ Phone _____

Responsible Party: Name _____ Relationship to Patient_____

Do you have insurance? _____ Yes _____ No

Primary: _____ ID#_____ Group _____

Subscriber Name _____ DOB _____ Relation _____

Secondary: _____ ID# _____ Group _____

Subscriber Name _____ DOB _____ Relation _____

OFFICE STAFF WILL NEED A COPY OF YOUR CURRENT INSURANCE INFORMATION AND ID

The information provided is correct to the best of my knowledge. I authorize Only Choice Urgent Care to provide medical services to myself/my minor child. I authorize my insurance company to pay all benefits otherwise payable to me for all services rendered. I authorize Only Choice Urgent Care to use this signature on all signature claims.

_____ _____

Patient/Legal Guardian Signature Date

11511 FM 1960 Ste 102 – Huffman, TX 77336 – Phone 281-324-1550 – www.onlychoicecare.com

Patient Name _____ DOB _____

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 communication or that a communication of PHI be made by alternative means.

It is important to note that communication may not always be secure. E-mails and text messages can be intercepected or corrupted by unintended parties. However, I would still prefer my provider contact me with results by the following means.

1. **Telephone Message**
   Preferred number(s): _____ Yes No
2. **E-mail Message**
   Primary e-mail address: _____ Yes No

Our staff will make an attempt to contact you by the primary telephone number or e-mail that you have chosen to list. If you choose not to list a phone or e-mail communication you will need to be seen in the office for any matter that pertains to you or minor child. (labs, medications, etc)

Persons allowed to call for records, receive reports/messages on my behalf, or that may pick up medications: [**Initial** all that apply and specify name(s)]
must update this form in the office. We will not accept verbel authorization

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

_____ _____
Patient/Legal Guardian Signature Date

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PATIENT ACKNOWLEDGEMENT AND AGREEMENT FOR MEDICAL SERVICES

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form. Patients must tell the staff if language interpreter services are necessary for your understanding of the written or spoken information given during your health care visits. A free interpretive service may not be immediately available and Only Choice Urgent Care may need to refer you to another healthcare facility to provide the services necessary for care.

No guarantee has been given as to the results that may be obtained from any services received. At any time, patients can change their mind about receiving medical services at Only Choice Urgent Care. Patients are responsible for all charges once seen by a provider. **Weight program and Medical visits are TWO SEPARATE charges**.

Some conditions and disease states require advanced healthcare services not provided at Only Choice Urgent Care. In these instances, you will be given referrals to see specialists and/or orders for special testing and procedures which may include, but are not limited to, CT, MRI, Ultrasound, EEG, Colonoscopy, Mammogram, etc. If the provider orders or recommends any of the above, it is the patient's responsibility for obtaining and paying for those services. In the case of emergency patients should seek care at an emergency room.

Treatment for Minors

All patients age 17 years and younger MUST HAVE a parent/legal guardian present for all office visits. A signed letter of consent and a copy of parent/legal guardian's photo ID is required for patient to be brought in by someone other than a parent (ex. grandparent, sibling, aunt, etc.)

HIPAA

Confidentiality will be maintained as described in the *Notice of Health Information Privacy Practices*. Confidentiality may be broken if you cannot be contacted when a life-threatening condition is suspected or detected.

Be advised that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law.

HIPAA information continues on next page….

Disability, Insurance Forms, Work Release Forms, etc.

There is a $25 per form charge to fill out disability, FMLA, and other health related forms. Please mail or leave forms at the front desk with your payment. Forms will not be completed until payment is received.
Please allow 3 – 7 business days for processing. You will receive a phone call once completed to pick up your form(s).
We will not mail, fax or e-mail these forms.

Medical Records

You may request a copy of your medical records by letter, please provide your current address and contact information. There is a $25 fee for the first 25 pages and $0.20 for each additional page. Please allow 14 business days from the day we receive your letter of request for processing. We will mail your records once processed.

Refills:

Refills for medications should be requested during office visits or by having the pharmacy contact the office. Calling the office for a refill request will **NOT** be addressed immediately.
Refills should be requested in a timely manner (3 days before running out).
Refills will be addressed at our earliest convenience, not all request will be addressed the same day. Allow 5 – 10 business days.

Only Choice Urgent Care will NOT refill any controlled substances without an office visit.

The providers at Only Choice Urgent Care will check the Texas Prescription Monitoring Program before prescribing any controlled substances if needed. You must meet all requirements before any such medication will be prescribed (weight management, hormone replacement therapy, etc.). These medications are only prescribed with an in office consultation, no refills are given.

Labs

Our office uses PathGroup Laboratory for all lab tests. We do not charge for any blood tests, cultures, etc. You will receive a bill from Path Group Lab for any testing. It is your responsibility to know which laboratory and labs tests are covered by your insurance. We are not responsible for any bill you may receive from the lab. Please be aware that most insurance company do not cover hormone blood tests.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that related to your past, present or future physical or mental health or condition and related health care services.

1. **Uses and Disclosures of Protected Health Information**
   - **Uses and Disclosures of Protected Health Information:** Your protected health information may be used and disclosed by your physician, our office staff and other outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.
   - **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
   - **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.
   - **Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Military Activity and National Security; Workers Compensation; Inmates; Required Uses and Disclosures; Under the Law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

2. **Your Rights:** Following is a statement of your rights with respect to your protected health information.
   - **You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
   - **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.
- **You may have the right to have your physician amend your protected health information**. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy official of your complaint. We will not retaliate against you for filling a complaint. You can contact our privacy official at:

HIPAA Privacy Official
212 E. Third St.
West Plains, MO 65775

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our office manager at (281) 324-1550.

I hereby acknowledge receipt of Only Choice Urgent Care's patient acknowledgement of medical services notice of health information privacy practices

_____ _____
Patient/Legal Guardian Print Date

_____ _____
Patient/Legal Guardian Signature Date

I witness the fact that the patient received the above mentioned information and said she/he read and understood same and had the opportunity to ask questions.

Signature of witness _____Date _____

☐ CHECK HERE IF PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW

Signature of any other person consenting _____Date _____

Relationship to patient _____

I witness the fact that the patient's legal guardian (or person consenting in her/his behalf) received the above mentioned information and said he/she read and understood same.

Signature of witness _____Date _____

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