Advanced URGENT CARE 24 HOUR

WELCOMES YOU!

Please PRINT and COMPLETE form in full. This form includes eight pages including this page.

Reason for your visit today is:

Patient Information

Patient Name (Last Name, First Name)	Social Security Number (last four) XXX - XX-	Birth Date (MM/DD/YYYY) / /		
Street Address	City	State	Zip	☐ Male ☐ Female

Marital Status: ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Single

Email Address @ .	Home Phone ( ) -	Cell Phone ( ) -
Emergency Contact Name:	Relationship:	
Phone: ( ) -	Note:	

I am financially responsible for the patient: (Skip this section if same as patient)

Name (Last Name, First Name)	Social Security Number (last four) XXX - XX-	Birth Date (MM/DD/YYYY) / /		
Street Address	City	State	Zip	☐ Male ☐ Female
Home Phone ( ) -	Cell Phone ( ) -	Relationship to patient ☐ Self ☐ Spouse ☐ Child ☐ Other		

Primary Insurance Policyholder			**Secondary Insurance Policyholder**		
Insurance Plan Name			Insurance Plan Name		
Policyholder Name (Last Name, First Name)	☐ Male ☐ Female		Policyholder Name (Last Name, First Name)	☐ Male ☐ Female	
Social Security Number (last four) XXX - XX-	Birth Date (MM/DD/YYYY) / /		Social Security Number (last four) XXX - XX-	Birth Date (MM/DD/YYYY) / /	
Street Address			Street Address		
City	State	Zip	City	State	Zip
Phone ( ) -	Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other		Phone ( ) -	Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other	

Referring Doctor and Employer Information

Name:	City:	Phone: ( ) -
Employer Name:	Employer's Location:	

What is your Pharmacy?

Pharmacy	Location

By my signature below, I hereby request and consent to medical treatment and I authorize the release of medical information as outlined in practice of information policy I have been given. I authorize payment directly to the physician or supplier for services rendered and I recognize that I am ultimately responsible for payment for services regardless of insurance coverage or non-coverage.

Please sign, date, and continue to the next pages...

Authorized Signature

Today's Date / /

STAFF USE ONLY. In reviewing the above information I find it to be current and accurate and I renew my above authorization: (initial and date here)

Please initial each policy acknowledging your acceptance of its contents.

OUR URGENT CARE POLICIES AND PROCUDURES

CO-PAYS	Co-Pays are due at time of service. Our urgent care does not bill for co-pays. We accept cash, check, Visa, MasterCard, Discover and American Express. _____ (initial)
INSURANCE CARDS	Insurance cards are required at every visit. If there are any changes to your insurance including, but not limited to, new insurance member identification number and/or group number please inform the urgent care. If you have not provided our urgent care with the correct insurance information, you will be responsible for any balance due. We are unable to re-submit insurance claims. _____ (initial)
SELF-PAY PATIENTS	If you do not have insurance, your balance is due at time of visit. Our urgent care accepts cash, check, VISA, MasterCard, Discover and American Express. _____ (initial)
WORKMAN'S COMPENSATION and MOTOR VEHICLE ACCIDENTS	If your visit will not be submitted under your insurance plan, our urgent care must have all necessary claim information before or at the time of your visit. If you are unsure of what information to bring, you should call our urgent care before your visit. We may need to reschedule your appointment until we have all the necessary claim information. If you do not provide us with the correct information then you will be personally responsible for outstanding account balances. _____ (initial)
BILLING STATEMENTS	Regularly our urgent care sends out a billing statement to every patient. The balance due is the remainder owed after your insurance has paid. It is your responsibility to pay your monthly statement each month even if you and your insurance company are disputing coverage. _____ (initial)
COLLECTIONS	If your account balance is unpaid and overdue after three monthly statements or more and you have not responded to any of our attempts to contact you, your account will be referred to a collection agency. Once your account is in collections you will be dismissed from our practice and any further communication concerning your account will be between you and the collection agency. Again, please note that we will only proceed to these measures if you do not respond to our attempts to communicate with you and set up a payment plan. _____ (initial)
PAYMENT PLANS	If you have negotiated a payment plan with us you are responsible for making timely and consistent monthly payments. We offer payment plans as a courtesy to our patients in time of need. If you fail to make your scheduled monthly payment and do not contact our urgent care before your scheduled due date, your account will be sent to collections for non-payment. _____ (initial)
LATE FOR APPOINTMENTS	Please try to make every effort to notify our urgent care if you will be arriving late. If you will be more than 30 minutes late, you may need to reschedule your appointment or we may ask that you wait until next open spot on schedule while we continue to see the patients who have been arriving on time. _____ (initial)
PAPERWORK TO BE FILLED OUT BY THE DOCTOR	An appointment may be required to have forms completed. Please check with the staff to see if your form will require an urgent care visit. If a scheduled appointment is required your co-pay is due at time of visit. _____ (initial)

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NOT SHOWING FOR YOUR SCHEDULED APPOINTMENT	We ask that 24 hour notice is given when canceling an appointment. No showing for an appointment could result in a $25.00 fee which is not covered by insurance. Frequent no-shows or cancellations could result in being discharged from the practice. _____ (initial)
CHANGE IN PERSONAL INFORMATION	Please call or write to the urgent care concerning any change of personal information such as your address, phone number, or who we may communicate information to concerning your health information, at your earliest convenience. Not updating personal information can delay communication regarding your health information. _____ (initial)
EXCHANGE OF MEDICAL INFORMATION	All request by patients must be signed and in writing by letter, fax or a medical release of information form. Verbal requests are not acceptable. A request is not necessary if the information is shared with a physician we referred you to. _____ (initial)
COPYING FEES	We do charge a fee for the copying of medical records. The fee and length of time to copy the medical record is dictated by the size of the chart. Please give the urgent care advance notice. Copying fee is due at time of pick up. A fee does not apply if the medical record is being transferred to another physician's office. _____ (initial)
DIAGNOSIS CODES	Our urgent care cannot recode an urgent care visit because your insurance does not cover certain visits; this is illegal and considered fraud. It is your responsibility to know what your insurance plan covers. Physicals, shots, and psychiatric care are a few examples of what some insurance companies may not cover. Always call your insurance company to verify coverage. It will be your responsibility to pay any unpaid amount that your insurance does not cover within 30 days. _____ (initial)
RESULTS FROM TEST	Our urgent care will notify you with the results from testing as soon as they become available to us and are reviewed by your doctor. If another physician ordered the tests and copies are sent to us, it is the responsibility of the ordering physician to contact you. Unless otherwise instructed we are unable to give out results the same day a test is performed. _____ (initial)
TEST ORDERS AND REFERRALS	This urgent care tracks test orders and referrals given to patients. An expected timeframe for completion of these tests are assigned. If we have not received a report within the expected timeframe, the patient will receive a letter reminding the patient of the recommendation and the reason for the recommendation. The letter will include a request that the patient respond to us as to their intent to follow-up. Further lack of response by the patient will be interpreted by the urgent care that the patient assumes sole responsibility for the consequences of their inaction on this matter. Noncompliance could result in being discharged from the practice. _____ (initial)
UNCOOPERATIVE PATIENTS	Physicians are not required to continue treatment of a patient who is uncooperative, refuses to follow treatment advice and/or presents difficulties in the doctor-patient relationship. Our goal is to try to accommodate all our patients' needs. Demanding and abusive language does not help us achieve that goal. Patients may be dismissed from our practice for non-compliance. _____ (initial)

NOTICE OF PRIVACY PRACTICES

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

This practice creates a medical record of your health information in order to treat you, receive payment for services delivered and to comply with certain policies and laws. We are also required by law to provide you with this Notice of our legal duties and privacy practices. In addition, the law requires us to ask you to sign an Acknowledgement that you received this Notice. We are required by federal and state law to maintain the privacy of your medical information Medical information is also called. **"Protected health information"** or **"PHI".** This is a list of some of the types of uses and disclosures of your **PHI** that may occur:

Treatment:	We obtain health information, or PHI, about you in order for us and others to treat you We may also send. Your PHI to another physician, facility or Counselor to which we refer you for treatment, care, procedures or testing. We may also use your PHI to contact you to inform you about alternative treatments or other health related benefits we offer. If you have a friend or family member involved in your care, we may give them PHI about you.
Payment:	We use your PHI to obtain payment for the services we render. For example, we send PHI to Medicaid, Medicare or your insurance plan to obtain payment for our services.
Healthcare Operations:	We use your PHI for our operations. For example, we may use your PHI in determining whether we are giving adequate treatment to our patients. From time — to — time, we may use your PHI to contact you to remind you of your appointment
LEGAL REQUIREMENTS	
Public Health:	We may disclose your PHI to prevent or control disease, injury or disability to report births and deaths, or reactions to medical devices or suspected cases of abuse or neglect.
Health Oversight Activities:	We may use and disclose your PHI to state agencies and federal government authorities when required to do so. We may also use your PHI in order to assist others in determining your eligibility for public benefit programs and coordinate delivery of those programs. For example, we must give PHI to the Secretary of Health and Human Services in an investigation into our compliance with the federal privacy rule.
Judicial and Administrative Proceedings:	We may use and disclose your PHI in judicial and administrative proceedings. Efforts may be made to contact you prior to a disclosure of your PHI to the party seeking the information.
Law Enforcement:	We may use and disclose your PHI in order to comply with requests in pursuant to a court order, warrant, subpoena, summons or a similar process. We may also use it to locate someone who is missing, to identify a crime victim, report a death or criminal activity, or in an emergency.
Avert a Serious Threat to Health or Safety:	We may disclose your PHI to avoid you or someone else getting hurt.
Work-related Injuries:	We may use or disclose PHI to an employer if they are conducting a medical workplace surveillance or to evaluate work related injuries.
Coroners, Medical	We may use or disclose PHI to a coroner or medical examiner in some situations. For example, PHI

Examiners and Funeral Directors:	may be needed to identify a deceased person or determine a cause of death. Funeral directors may need PHI to carry out their duties.
Armed Forces:	We may use or disclose the PHI of Armed Forces personnel to the military for proper execution of a military mission or to determine eligibility for benefits.
National Security and Intelligence:	We may use of disclose PHI to maintain the safety of the President or other protected officials for the conducting of National Intelligence activities.
Research:	You will need to sign an Authorization Form before we use or disclose PHI for research purposes except in limited situations like if you wanted to participate in a research or clinical study.
Fundraising:	If we Undertake any fundraising activities, we may contact you about the activity itself. We do not engage in marketing activities, and need your permission to do So.
ILLINOIS LAW	
Illinois law also has certain requirements that govern the use or disclosure of your PHI. In order for us to release information about mental health treatment, genetic information, your AIDS/HIV status or alcohol and drug abuse treatment, you will be required to sign an Authorization form unless State Law allows us to make the specific type of use or disclosure without it. You have certain rights under Federal and State laws relating to your PHI. Some of these rights are described below:	
Restrictions:	You have a right to request restrictions on how your PHI is used for treatment purposes, payment and health care operations. We are not required to accommodate your request.
Communication:	You have a right to receive confidential communications about your PHI. For example, you may request that we only call you at home. If your request is reasonable, it may be accepted.
Inspect and Access:	You have a right to inspect Your health information: This includes billing and medical record information. You may not inspect your record in some cases. If you request to inspect your record and are denied, we will send you a letter informing you of the reason why and explaining your options. You may have a copy of you PHI in most situations. If you request a copy of your PHI, we may charge you a fee for making copies and mailing them to you, if you ask us to "nail them.
Amendments of your Records:	If you believe there is an error in your PHI, you have a right to request that we amend them. We are not required to agree with your request to amend.
Accounting of Disclosures:	You have a right to receive an accounting of disclosures that we have made of your PHI for purposes other than treatment, payment, healthcare operations or release made pursuant to your authorization,
Copy of Notice:	You have a right to obtain a paper copy of this Notice, even if you originally received the Notice electronically. We have also posted this Notice in our urgent care.
Complaints:	If you feel that your privacy rights have been violated, you may file a complaint with us by calling our Medical Records department at 708 923-4660. We will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services in Washington, DC. We are required to abide with the terms of the Notice currently in effect; however, we may change this Notice. If we materially change this Notice, you can obtain a copy by stopping by our urgent care and picking one up. Changes to the Notice are applicable to the health information we already have.

Advanced URGENT CARE 24 HOUR

PRIVACY PRACTICES AND URGENT CARE POLICY & PROCEDURES

Please let us know how we can discuss your medical care.

Patient Name (Last Name, First Name)	**Birth Date (MM/DD/YYYY)** / /

1	My medical care may be discussed with my: ☐ Spouse ☐ Parent ☐ Children ☐ Significant other List names that apply (Last Name, First Name): • _____ • _____ • _____ • _____
2	Test results may be left on my answering machine/voicemail ☐ Yes ☐ No
3	Appointment information may be left on my answering machine/voice mail ☐ Yes ☐ No
4	Medical information may be emailed to me ☐ Yes ☐ No
5	Preferred form of commination ☐ Home phone ☐ Cell phone ☐ Email

I, **(patient signature)** _____ have received the notice of privacy practices and the list of urgent care policy and procedures from Advanced Urgent Care.

For personal representative of the patient if the patient is a minor or the patient is unable to make their own medical decisions.	
Print name of personal representative (Last Name, First Name)	
Describe personal representative relationship	
Signature of personal representative	Today's date (MM/DD/YYYY) / /

STAFF USE ONLY. In reviewing the above information I find it to be current and accurate and I renew my above authorization: (initial and date here)

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

As required by Privacy Regulations, this practice may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this urgent care and any of the employees to use or disclose my Patient Health information to person(s), entity(s), or business associates of this Urgent Care, for specific medical reports and/or any and all information from this urgent care. i.e. lab, specialist, hospitals, etc.	
Signature of patient or personal representative	Today's date (MM/DD/YYYY) / /

Patient Health information authorized to be disclosed to who: i.e. employer (If not applicable, please skip this section)	
List names that apply (Last Name, First Name): • _____ • _____	
For specific purpose of:	
Effective dates for this authorization: (MM/DD/YYYY) / / through (MM/DD/YYYY) / / **This authorization will expire at the end of the above period.**	
Signature of patient or personal representative	Today's date (MM/DD/YYYY) / /

I understand I have the right to:

I. Revoke this authorization by sending written notice to this urgent care and that revocation will not affect this urgent care's previous reliance on the uses or disclosure pursuant to this authorization.
II. Knowledge of any remuneration involved due to any marketing activity as allowed by the authorization and as a result of the authorization.
III. Inspect a copy of Patient Health Information being used or disclosed under Federal Law.
IV. Refuse to sign the authorization.
V. Receive a copy of this authorization.
VI. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits whether or not I provide authorization to use or disclose protected Patient Health Information.

Patient Name (Last Name, First Name)	Birth Date (MM/DD/YYYY) / /	Today's date (MM/DD/YYYY) / /

Street Address	City	State	Zip code
Signature of patient or patient authorized reprehensive	Authorized signature of facility		

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First Visit Survey

Thank you for choosing us as your 24 Hour Urgent Care. Please share with us how Advanced Urgent Care helped you or your loved one to learn about it.

How did you learn about Advanced Urgent Care (check more than one, if applicable)?

- ❑ Family/Friend ❑ Television ❑ Radio
- ❑ Workplace ❑ Direct Mail ❑ Flyer
- ❑ E-mail ❑ News Paper ❑ Billboard
- ❑ Outside Signs
- ❑ Doctor Referral- her/his name:……
- ❑ Internet Search? Where……
- ❑ Magazine- Which one……
- ❑ Other (please specify): ……

Do you have a Primary Care Physician (also known as family doctor)?

❑ Yes ❑ No

if yes, would you tell us his/her name? …….....

Tell us about you?
Gender:

❑ Male ❑ Female

Age Group (Patient or personal representative):

- ❑ 15-17 years old ❑ 18-24 years old ❑ 25-34 years old
- ❑ 35-44 years old ❑ 45-54 years old ❑ 55-64 years old
- ❑ 65-74 years old ❑ 75 years or older

If you have any comment please do not hesitate to contact the manager at: wtinawi@24advancedcare.com or leave your comment in the Comment Box in the waiting area.

We appreciate your input. Thank you.

STAFF USE ONLY. In reviewing the above information I find it to be current and accurate and I renew my above authorization: (initial and date here)