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Date: ____________________________

Reason for Visit: ____

Is this a WORK related problem?___YES ___NO or AUTO ACCIDENT related? ___YES ___NO

Last Name: ______________________________________ First Name: _____________________________ M.I. _____

Address: ____

City: _________________________________ State: ___________________ Zip Code:____________________

Birth Date: ____________________ Age: ______ Sex: ______ Social Security # ___________________________

Race: ___________________________ Primary Language: _________________________ Hispanic: YES NO

Marital Status: Single Married Divorced Widowed Email Address: ____

Phone (8am-4pm):_________________________ Home:_________________________ Cell:_________________________

Employer: ____ Occupation: ____

Emergency Contact: _______________________________ Emergency Contact Number: ___________________________

Relationship to Patient__________________________

Patient's Relationship to Insurance Subscriber (please circle one): Self Spouse Dependent Other

Subscriber Name (if different from patient): _____________________________Subscriber Birth Date: _________________

Is insurance subscriber's address is different from above ___YES___NO If yes, please fill in below:

Address: ____

City: _________________________________ State: ___________________ Zip Code: ____________________

☐ **YES,** I would like to receive periodic health related e-mail correspondence ☐ **NO,** thank you

Please list any impairment(s) (visual, hearing, or any other): ____

Family Physician: ____ Phone: ______________________________

Were you referred by a physician: **YES NO** If so, please list their name ____

Please list a pharmacy below or check one from the list provided below
NOTE: Please keep in mind the hours of the pharmacy when making your selection.

Pharmacy Name: _______________________________ City: ______________________________________

Cross Roads: ____

Grand Prairie Urgent Care
5204 S. Hwy 360, Suite 400
Grand Prairie, TX 75052
Tel: (972) 755-1785/ Fax : (972) 602-4522

Patient Financial Responsibility Form

Thank you for choosing Grand Prairie Urgent Care. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the cost of his/her own treatment and care.
- We are pleased to assist you by billing our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.
- Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatments not covered by their insurance plan. Payment is due at the time of service and for convenience, we accept cash and most major credit cards at our office.
- Patients may incur, and are responsible for the payment of additional charges at the discretion of Grand Prairie Urgent Care. These charges may include (but are not limited to):
    - Charge for the copying and distribution of patient medical records($20 for first 10 pages .25 per page thereafter)
    - Charge for extensive forms completion ($20)
    - Any cost associated with collection of patient balances
- If there is a remaining balance on your patient account and several attempts have been made to collect monies owed, Grand Prairie Urgent Care reserves the right to charge an amount up to $500 to the credit card on file to settle the outstanding debt.

Patient Authorizations

- By my signature below, I hereby authorize Grand Prairie Urgent Care and the physicians, staff and hospitals associated with Grand Prairie Urgent Care to release Medial and any other information acquired in the course of m examination and/or treatment (with the exceptions stipulated below) to the necessary insurance companies, third party payers, and/or other physicians and/or healthcare entities required to participate in my care. By checking one or more of the following boxes, the health information I authorize to be released may include any of the following:
    - Diagnosis, evaluation, and/or treatment for alcohol and/or drug abuse
    - Records of HTLV-III or HIV testing (AIDS test) result, Diagnosis, and/or treatment
    - Psychiatric and/or psychological records or evaluation and/or treatment for mental, physical and/or emotional illness including narrative summary, test, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluations
- By my signature below, I hereby authorize assignment of financial benefits directly to Grand Prairie Urgent Care and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.
- By my signature below, I authorize Grand Prairie Urgent Care personnel to communication by mail, voicemail, and/or email according to the information I have provided in my patient registration:

_______________________________________ _____________________________

Signature of Patient or Guardian Date

Waiver of Patient Authorization : (Self Pay)

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

____ ___________________________

Signature of Patient or Guardian Date

Grand Prairie Urgent Care

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize Grand Prairie Urgent Care to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below. This authorization permits Grand Prairie Urgent Care to use or disclose to

____
Person or entity to receive the information

the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.).

____

____

____

This authorization will expire on ______________________________.
(Expiration date or defined event).

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Grand Prairie Urgent Care. has acted in reliance upon this authorization. My written revocation must be submitted to Grand Prairie Urgent Care, 5204 S. Hwy 360, Suite 400 Grand Prairie, TX 75052.

Signed by: ______________________________ ______________________________
Signature of Patient or Legal Guardian | Relationship to Patient

______________________________ ______________________________
Print Patient's Name | Date

____
Witness

Grand Prairie Urgent Care

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been offered a copy of the Notice of Privacy Practices for the Practice of Grand Prairie Urgent Care.

________________________________	________________________________
Patient/Guardian Signature	Witness
________________________________	________________________________
Print Name of Patient	Patient's Date of Birth
________________________________	________________________________
Date of Signature	Date

Documentation of Failure to Obtain Signed Acknowledgement:

On ____, this Acknowledgement of Receipt of Notice of Privacy Practices was presented to ___________________________________ (the Patient/Guardian). The Patient /Guardian refused to provide a signature when requested.

Privacy Officer:

Carolyn Scott, M.D.
5204 S. Hwy 360, Suite 400
Grand Prairie, TX 75052
(972) 755-1785

Grand Prairie Urgent Care

PATIENT CONSENT FOR TREATMENT AND FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I AUTHORIZE MEDICAL TREATMENT AS DEEMED NECESSARY AND APPROPRIATE BY THE PHYSICIANS OF GRAND PRAIRIE URGENT CARE AND THEIR EMPLOYEES PARTICIPATING IN MY CARE.

With my consent, Grand Prairie Urgent Care, may use and disclose Protected Health Information (PHI), about me to carry out treatment, payment and healthcare operations. Please refer to the Grand Prairie Urgent Care's **Notice of Privacy Practices** for a more complete description of such uses and disclosures.

With my consent, Grand Prairie Urgent Care may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment or healthcare operations, such as appointment reminder, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Grand Prairie Urgent Care may relay any items that assist the practice in carrying out treatment, payment or healthcare operations such as appointment reminders, insurance items, statement reminders and any information pertaining to my clinical care, including laboratory results among others, to:

PLEASE LIST PERSON(S) THAT WE CAN SPEAK WITH ON YOUR BEHALF
(PLEASE LIST BOTH PARENTS OR GUARDIANS FOR MINOR PATIENTS)

______________________________	______________________________
Name	Relationship to Patient
______________________________	______________________________
Name	Relationship to Patient

With my consent, Grand Prairie Urgent Care may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment or healthcare operations such as long as they are marked.

With my consent, I authorize Grand Prairie Urgent Care to release medical information regarding the care and treatment I have received from this office to the physicians I have listed on the reverse side of this form.

I have the right to request that Grand Prairie Urgent Care restrict how it uses or discloses my PHI to carry out treatment, payment or healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I authorize payment of insurance benefits directly to Grand Prairie Urgent Care. I understand that I am fully responsible for any medical or surgical charge incurred in the course of my treatment including those that are considered rejected, co-pay, deductible or other type of unpaid service in excess of any hospitalization or health insurance that might be applicable.

I hereby authorize my physician to release pertinent information to my health insurance companies required in the course of my examination or treatment.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Grand Prairie Urgent Care has the right to decline to provide treatment to me.

By signing this form, I am consenting Grand Prairie Urgent Care's use and disclosure of my personal health information to carry out treatment, payment and healthcare operations.

______________________________	______________________________
Patient/Legal Guardian Signature	Date
______________________________	______________________________
Printed Name of Patient/Legal Guardian	Witness

Grand Prairie Urgent Care
5204 S. Hwy 360, Suite 400
Grand Prairie, TX 75052
Tel: (972) 755-1785/ Fax : (972) 602-4522

Authorization for Release of Information to Designated Person(s)

Patient Name: _______________________________Date of Birth:______________________________
This form is part of the Federal Health Insurance Portability and Accessibility Act of 1996 (HIPAA) requirements for patient privacy. Signing this form and naming a person(s) who can receive your health information allows the staff of Grand Prairie Urgent Care to release information regarding your healthcare.

Person(s) who can receive information for you:

Name: _________________________________Relationship: _____________________________________

Name: _________________________________Relationship: _____________________________________

Name: _________________________________Relationship: _____________________________________

I hereby authorize Grand Prairie Urgent Care's staff to use and disclose my individually identifiable health information as described above. I understand that this authorization is voluntary and that I may revoke this authorization at any time by notifying Grand Prairie Urgent Care in writing. I understand that once this information is disclosed the released information may no longer be protected by federal privacy regulations. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional on signing this authorization. This authorization shall be in force and effective until revoked by the patient or representatives signing the authorization.

____ __________________________________

Patient Signature or Guardian, if patient is a Minor Date

Grand Prairie Urgent Care

PATIENT CONSENT FOR TREATMENT AND FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize medical treatment as deemed necessary and appropriate by the physicians of Grand Prairie Urgent Care, and their employees participating in my care.

With my consent, Grand Prairie Urgent Care, may use and disclose Protected Health Information (PHI), about me to carry out treatment, payment and healthcare operations. Please refer to the Grand Prairie Urgent Care **Notice of Privacy Practices** for a more complete description of such uses and disclosures.

With my consent, Grand Prairie Urgent Care may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment or healthcare operations, such as appointment reminder, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Grand Prairie Urgent Care may relay any items that assist the practice in carrying out treatment, payment or healthcare operations such as appointment reminders, insurance items, statement reminders and any information pertaining to my clinical care, including laboratory results among others, to:

PLEASE LIST PERSON(S) THAT WE CAN SPEAK WITH ON YOUR BEHALF
(PLEASE LIST BOTH PARENTS OR GUARDIAN(S) FOR MINOR PATIENTS)

Name	Relationship to Patient
______________________________	______________________
______________________________	______________________

With my consent, Grand Prairie Urgent Care may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment or healthcare operations such as long as they are marked.

With my consent, I authorize Grand Prairie Urgent Care to release medical information regarding the care and treatment I have received from this office to the physicians I have listed on the reverse side of this form.

I have the right to request that Grand Prairie Urgent Care restrict how it uses or discloses my PHI to carry out treatment, payment or healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I authorize payment of insurance benefits directly to Grand Prairie Urgent Care. I understand that I am fully responsible for any medical or surgical charge incurred in the course of my treatment, co-pay, deductible, all other charges determined to be patient responsibility or other type of unpaid service in excess of any hospitalization or health insurance that might be applicable.

I hereby authorize my physician to release pertinent information to my health insurance companies required in the course of my examination or treatment.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Grand Prairie Urgent Care has the right to decline to provide treatment to me.

By signing this form, I am consenting Grand Prairie Urgent Care use and disclosure of my personal health information to carry out treatment, payment and healthcare operations.

______________________________ ______________________
Patient/Legal Guardian Signature Date

______________________________ ______________________
Printed Name of Patient/Legal Guardian Witness

Patients' Rights

- **The Right to Information.** Patients have the right to receive accurate, easily understood information to assist them in making informed decisions about health care involving Grand Prairie Urgent Care facilities and professionals.
- **The Right to Respectful Care.** Every patient has the right to respectful and considerate care without discrimination.
- **The Right to be a Full Partner in Health Care Decisions.** Patients have the right to fully participate in all decisions related to their health care. Patients who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members, or other conservators.
- **The Right to Identification.** Patients have the right to know the identity of physicians, medical assistants, and others involved in their care, as well as when those involved are students or other trainees.
- **The Right to Care Without Discrimination.** All patients have the right to considerate, respectful care from all Grand Prairie Urgent Care employees at all times and under all circumstances. Patients must not be discriminated against in the provision of health care services, consistent with the benefits covered in their policy and/or as required by law.
- **The Right to Privacy**. Patients have the right to communicate with health care providers in confidence and to have the confidentiality of their personally-identifying health care information protected.
- **The Right to Review.** Patients have the right to review and copy their own medical records and request amendments to their records, as well as have the information in their records interpreted or explained to them, except as restricted by law. Patients have the right to review any disclosures of their health information, in accordance with law and regulation.
- **The Right to Complaint Resolution.** Patients have the right to a fair and efficient process for resolving any differences with Grand Prairie Urgent Care, its policies, guidelines, or health care providers.
- **The Right to Have Acute Pain Issues Addressed.** Grand Prairie Urgent Care respects the patient's right to management of pain as appropriate and consistent with clinical practice guidelines.
- **The Right to Express Safety Concerns.** Patients have the right to contact Jennifer Wheeler in the Grand Prairie Urgent Care Safety Office at (469) 814-8475 with any safety concerns.
- **The Right to Refuse Care.** Patients have the right to refuse care or services even if it is against medical advice.

Patients' Responsibilities

- **The Responsibility to be Accountable.** In a health care system that affords patients their rights and protections, the patient must also take greater responsibility for maintaining good health.
- **The Responsibility to Ask Questions.** Patients should ask questions when they do not understand their care, treatment, or services or what they are expected to do.
- **The Responsibility to Follow Instructions.** Patients should follow their plan of care, treatment, or services. They should also express any concerns about their ability to follow the proposed plan. Patients should also accept their share of responsibility for outcomes of not following their plan of care, treatment, or service.
- **The Responsibility to Show Respect and Consideration.** Patients should be considerate of the organization's physicians, staff, and property, as well as other patients and their property.
- **The Responsibility to Meet Financial Obligations.** Patients are expected to meet all financial obligations agreed to with Grand Prairie Urgent Care.