



Patient Registration Form

Date: ___/___/___ Marital Status: Single Married Divorced Separated Widowed

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

Maiden Name: _____ Birth Date: ___/___/___ Age: _____

Male Female Social Security Number: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Work Phone: (_____) _____ - _____ Email: _____@_____

Referred by: _____

Ethnicity: (please select) Hispanic/Latino Not Hispanic/Latino Decline

Race: (please select) White Hispanic Black/African American American Indian/Alaskan Native

Asian Native Hawaiian/Pacific Islander Preferred Language: _____

Preferred Local Pharmacy: _____

Mail Away Pharmacy: _____

ALL INSURANCE AND SELF PAY PATIENTS: ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT'S ACCOUNT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIERS PAYMENTS; HOWEVER, IF INSURANCE IS DENIED OR INSURANCE INFORMATION IS NOT RECEIVED AT THE TIME OF SERVICE, THE PATIENT/GUARDIAN IS RESPONSIBLE FOR ALL APPLICABLE FEES. IT IS CUSTOMARY TO PAY APPLICABLE CO-PAY CHARGES WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADANCE WITH OUR OFFICE MANAGER.

If visit is to be submitted to an insurance company, please read and initial the following: I request that payment of authorized Medicare/or other Insurance Carrier of benefits be made either to me or on my behalf to Treasure Coast Urgent Care for any services furnished to me by that party. Regulations pertaining to Medicare assignments of benefits apply. I authorize any holder of medical or other information about me, to release to the Social Security Administration and CMS or its intermediaries or carriers any information needed for this or a related Medicare/Other Insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical Insurance benefits to the party who accepts the assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section 1128B of the Social Security Act and 31 U.S. C3801-3212 provides penalties for withholding this information).

Insurance Information

(Please make sure that the front desk has scanned in a copy of your photo ID and insurance card)

Subscriber's Name: _____ Date of Birth: ___/___/___

Relationship to patient: _____ Phone Number: (_____) _____ - _____

Please indicate primary insurance: _____

Please list secondary insurance if applicable: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance that is left over. I also authorize Treasure Coast Urgent Care to release any information treatment required to process my claims.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____



New Patient Medical History Form

First Name: _____ Last Name: _____ Date of Birth: ____/____/____

Reason for today's visit:

Allergies: PENICILLIN SULFA ASPIRIN IBUPROFEN IODINE Others:

Current Medications:

<u>Name</u>	<u>Dosage</u>	<u>How many do you take & how many times per day</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medical History: (Please mark any conditions that you have had or have)

- | | | | |
|---------------------|-------------------------|----------------|--------------------------|
| Abnormal EKG | Anemia | Asthma | Breast Lump |
| Cancer: _____ | Coronary Artery Disease | Depression | Diabetes Type I or II |
| High Cholesterol | Emphysema | Heart Attack | Hepatitis (type: _____) |
| High Blood Pressure | Hyperthyroidism | Hypothyroidism | Kidney Disease or Stones |
| Mental Illness | Migraines | Osteoarthritis | Osteoporosis |
| Seizures | Stomach Ulcer | Stroke | Tuberculosis |

Please list any others or clarification of anything circled above:

Surgical History:

Have you ever had surgery? YES NO

If yes, please list the surgery and the date below. If you are not sure of the date, please give approximation.

Date	Surgery

Family History:

If any of your close family members (grandparents, parents, siblings, children, aunts, and uncles) have had any of the conditions listed below. **Please be sure to list if the member is paternal or maternal when necessary.**

Cancer (list type, if known): _____

Diabetes (list type, if known): _____

Heart Disease/High Blood Pressure: _____

Stroke: _____

Thyroid Disease: _____

Mental Health History: _____

Health Habits:

Smoking

Have you ever smoked? Never Former Current

If yes, how many years have you smoked or did you smoke? _____ If you did quit, what year? _____

Former or current smokers, please answer the amount: _____ packs per day

Caffeine

Do you drink caffeinated beverages? YES NO Decaffeinated Only

Coffee: How many on average per day _____ week _____

Tea: How many on average per day _____ week _____

Soda: How many on average per day _____ week _____

Alcohol

Do you drink alcoholic beverages? YES NO Former Alcoholic

If yes, what beverage do you typically drink? _____

How many on average per day _____ or week _____ or month _____

Exercise

Never 1 x week 2-3 x week 4-5 x weekDaily

Preferred exercise routine: _____

Substance Abuse

Do you have any history of substance abuse? YES NO

If yes, please list the substance(s): _____

Mental Health

Do you have any history of mental illness? YES NO

If yes, please list the illness(s): _____

Communicable Disease

Do you have any history of communicable diseases? YES NO

(this would include STD's, hepatitis, tuberculosis, etc...) If yes, please list the disease(s) below:

Patient Signature: _____ Date: _____

HIPAA Medical Release Form



Health Insurance Portability and Accountability Act – Privacy Form

ACKNOWLEDGEMENT AND NOTICE OF PRIVACY PRACTICES & PERMISSION TO SHARE HEALTH INFORMATION

Patient Name (please print)

I understand that my medical records are protected by federal law and that the information can only be released as per the Health Information Privacy and Portability Act. *(A copy is available upon request at the front desk)*

All Forms

Electronic copy or web-based portal ONLY

Hard Copy ONLY

NOTIFICATION OF FAMILY AND FRIENDS

I hereby authorize **Treasure Coast Primary Care** to disclose my protected health information to the following individual(s):

Name	Email	Phone/Fax
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_____ Name	_____ Email	_____ Phone/Fax
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I understand that the above may not be covered by state/federal rules governing privacy of data and may be permitted to further share information provided to them.

NOTIFICATION OF PHYSICIANS

I hereby authorize **Treasure Coast Primary Care** to disclose my protected health information to the following physician(s):

Physician Name or Practice	Email	Phone/Fax
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_____ Physician Name or Practice	_____ Email	_____ Phone/Fax
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I understand that the above may not be covered by state/federal rules governing privacy of data and may be permitted to further share information provided to them.

NOTICE OF VOICEMAIL AND MESSAGES

Voice messages may be left on the phone number(s) provided: YES NO

This includes lab results, medications or any other pertinent information about your health care and health records.

RESTRICTIONS ON THE USE & DISCLOSURE OF YOUR HEALTH INFORMATION

I understand that I may request certain restrictions on the use and disclosure of my health information.

I REQUEST THE FOLLOWING RESTRICTIONS:

- Mental Health Records
- Communicable diseases including, but not limited to, HIV/AIDS, Alcohol/Drug abuse, Genetic information
- Other (Specify) _____

Signature of Patient

Date

*I understand that I can revoke this authorization to share my health data at any time by submitting a request in writing to: **TREASURE COAST URGENT CARE***

MEDICAL RECORDS RELEASE

The following patient requested that their records be released as listed below.

RE: PATIENT: _____ DOB: _____ / _____ / _____

SSN: _____ DATES NEEDED: _____ ALL

RELEASE RECORDS FROM: _____

ADDRESS: _____

PHONE: _____ FAX: _____

RELEASE RECORDS TO: _____

ADDRESS: _____

PHONE: _____ FAX: _____

Health Information to be disclosed upon the request of the person named above.

Disclose my complete health record
(Including but not limited to diagnoses, lab tests, prognosis, treatment and billing for ALL conditions)

Disclose my health record as above BUT DO NOT INCLUDE

Mental Health Alcohol/Drug Treatment

Communicable Diseases (including HIV & AIDS)

Other (please specify) _____

FOR THE PURPOSE OF CONTINUITY OF CARE UNLESS OTHERWISE NOTED: _____

Pursuant to Florida Law, the records may be used only for the purpose provided and to whom requested. Any information may not be disclosed to any other person without the specific written consent of the undersigned. Changes are in compliance with Florida Law. I understand I may revoke this consent at any time before the information has been released.

Name of the Individual Giving this Authorization (print)

Date of Birth

Signature of the Individual Giving this Authorization

Date

Witness: _____

Date: _____

PATIENT PORTAL AUTHORIZATION

Authorization to disclose health information via electronic transmission

Patient Name: _____

E-mail: _____

Date of Birth: _____ / _____ / _____

By signing this form, I authorize **Treasure Coast Primary Care / Treasure Coast Urgent Care** to communicate via a personal, secured access Patient Portal with me for my medical care and treatment. Treasure Coast Urgent Care will provide notices via your personal e-mail that information can be found in your Patient Portal. No personal health information is transmitted via or into your personal e-mail. I understand that the following types of protected health information may be used, disclosed, and retained by the health care providers of Treasure Urgent Care as a result of the communications:

- **My Personal Health Information**
- **Electronic Displays of Radiological Images (X-rays)**
- **Laboratory Test Results / Pathology Reports**
- **Other Diagnostic Testing**

Patients and/or personal representatives who want to communicate with their health care providers by clinic Portal should consider all of the following issues before signing this authorization.

- Portal communication is a convenience and not appropriate for emergencies or time-sensitive issues.
- Portal Messages received by us can be forwarded, printed and/or read, and stored by our staff members.
- We advise caution when communicating highly sensitive or personal information via Portal messages. (*i.e. HIV status, mental illness, chemical dependency, and workers compensation issues*)
- Clinically relevant messages and responses will be documented in your medical record. Treasure Coast Urgent Care will not be liable for information lost or misdirected due to technical errors or failures.
- Treasure Coast Urgent Care does not own or have any interest in the Portal website. Our EMR software provides the Portal as a secure conduit in which communication with our data base is managed.
- I understand that I may revoke this authorization at any time in writing to Treasure Coast Urgent Care.
- I understand that if I revoke this authorization, it will not apply to any information already released.

I understand that I may refuse to sign this authorization and understand that Treasure Coast Urgent Care cannot deny or refuse to provide treatment, payment, or medical records if I refuse to sign this authorization.

I have read and understand the information in this authorization form.

Patient or legal guardian signature

Date

PATIENT PORTAL PROCESS/INFORMATION

INFORMATION

At **Treasure Coast Urgent Care** we offer HIPAA compliant electronic access to your patient record. This is a convenient way for you to have quick and anytime access to your medical care and treatment you receive at the clinic. This secure portal is offered to you through EMD's, the electronic health record program that is used by **Treasure Coast Urgent Care**.

First, you will need to sign a portal authorization form

This is available via our website at www.tcurgentcare.com under Resources >Patient Forms. Under the tab 'Portal Authorization' click on the form to fill out in Google Chrome or other PDF viewer. You may also obtain a copy in any of our office locations.

Second, you will be emailed a registration link

Follow the directions in the email to complete the registration process. You can use your email address as your user name and create a password of your choice. We recommend 6-8 characters and the use of at least one capital and number.

Once completed, you will have HIPAA compliant access to your health history including medication history, secure email directly with your provider and you'll be able to request copies of your labs, make appointments, and order some medication refills. **Please treat this login information as you would any confidential login.**

TYPES OF COMMUNICATION AVAILABLE TO YOU VIA THE PORTAL:

- Send/receive messages to/from clinic staff including directly to/from your provider
- Receive lab or diagnostic test results
- Request a physician referral
- Request an appointment
- Request a refill of your medication(s)
- You can also view/update your current medication list, demographic information, and login information