Champlain Valley Urgent Care

Initials__________

Date__________

Patient Information Sheet

(Private Patients)

Please Print Neatly

Patient Name____Date of Birth ____________

Permanent mailing Address____

City____________________ State_____________ Zip_________Male ____Female_________

SSN____________________HM #___________________ Wk #_____________Cell #____________

Driver's License #: ______________________________ State: ________

Email Address: ____

Marital Status (**please circle one**) Single Married/Civil Union Other____________

Occupation ____________________________ **(if student, you must fill in parents address below)**

Emergency Contact_______________________________________Phone __________________

Local Contact (If from out of state)/ Hotel __________________________ Room #___________

Local Phone __________________________How long will your stay be? __________________

Insurance policy holder information

Insurance Policy Holders Name__________________________Policy holders SSN _____________

Policy holder_____________________Date of Birth of policy holder______________

Parent/Guardian Information

Parent/Guardian Name_____________________________________Date of Birth_____________

Address (if different from above)__________________________________City_______________

State __ Zip_________Home Phone______________ Work Phone______________

Relationship to Insured:_______________________

Your Personal Health Information is Kept Private by Champlain Valley Urgent Care
In accordance with the federal HIPAA regulation, we are required to follow very strict regulation as it pertains to your health information. Please see our Notice of Privacy Practices for more specifics on this issue.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Nancy Fitzgerald. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Consent for Treatment

I hereby authorize Champlain Valley Urgent Care, its physicians, employees, or agents, together with any designated laboratories to perform a physical examination and/or any medical treatment deemed necessary by the treating physicians. This includes any medical examinations, x-rays, medical procedures, and medical, diagnostic, or laboratory tests ordered by the treating physician to be carried out by the designated clinic staff.

Controlled Medication Policy

It is our policy not to prescribe narcotics or other controlled medications to new patients unless there is a specific indication such as a fracture.

We **do not** prescribe narcotic medication for the following:

- Back pain
- Headache
- Chronic medical problems

We do not prescribe the following medications: **Methadone, Morphine, (Hydromorphone), Dilaudid, Oxycodone (Oxycontin, Percocet), Ritalin (Amphetamines), Soma.**

Any medications prescribed to patients are solely at the discretion of the clinician.

Release of Information

I authorize Champlain Valley Urgent Care to disclose to my employer, prospective employer, insurance company, or any third party payer all medical information, test results and findings made during the course of examination or treatment. I authorize the office to release any appropriate information concerning my medical history, examination, treatments or other diagnostic procedures to health insurance plans, third party administrators, or any other official requestors.

Patient/Guardian Signature: X____ Date: ____________

Name of patient (please print neatly) ___________________________________

Signature of Patient/Guardian ____ Date ______________

Please read this financial policy statement completely. It is important for you to understand our financial policies. You should also be familiar with your health insurance policy and its limitations.

1**. If you do not have insurance or we do not participate with your insurance company, payment is due at the time of service**. We accept all major credit cards, cash, and checks when a driver's license is available.

2. Please note that your health insurance is an agreement between you and your insurance company. We do not know the details of your policy*. As a service to you, we will file your insurance claim with your insurance company, provided you have your insurance card, we are able to verify your benefits, and we have a billing relationship with your insurance carrier.*

You are responsible for knowing the details of your insurance plan. If any referrals are needed or any other information is required to process the claim, you are responsible for doing so within 30 days of your receiving such notice from us or from your insurance company. If your visit is denied because of any negligence on your part, you are responsible for the bill in full.

If your insurance company does not pay Champlain Valley Urgent Care within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a co-payment at the time of your visit. All co-insurance or deductible amounts will be due within 30 days of the date of the statement.

4. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and mail you a claim form for you to submit on an unassigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service. If for some reason your insurer pays us, we will send you a check for the amount they pay within a reasonable amount of time after we receive it.

5. **Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due within 30 days from the date of the statement from our office.**

6. If you do not meet your financial obligations for payment on any medical services received from our office within 90 days of statement date, we reserve the right to turn your account over to a collection agency. **A $12.00 fee will be added to your balance for the first phase of the collection process. If you do not pay the complete bill within 30 days from entry into the first phase of collections, you will be transferred to the second phase of collections where 50% of your total bill will be added to your existing balance.**

7. As of 5/1/2007 we will be assessing a fee for patients who arrive near closing time, and are treated after our normal closing hours. Some insurance companies pay for this fee, while others do not.

I have read and understand Champlain Valley Urgent Care's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice without advanced notice.

X ____

Signature of Patient or legal guardian   Date

General Medical History

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

Name of Primary Care Physician: _______________________________ ❑ None

Drug Allergies	**Current Medications**
________________________________	____
________________________________	____

Do you now have, or have you had in the past, any of the following? If yes, please give brief details.

Condition	No	Yes	Details
1. Skin problems			
2. Bleeding disorders			
3. Endocrine disorders (Diabetes, thyroid disease)			
4. Back or neck injury/disease			
5. Arthritis			
6. Other muscle/joint problems (Fractures, etc)			
7. Visual/Eye problems			
8. Ear/hearing problems			
9. Nose or throat problems			
10. Breathing or lung problems			
11. Heart of blood vessel problems (high blood pressure/history of heart attack)			
12. Stomach, liver, or intestinal problems			
13. Bladder or kidney problems			
14. Nervous system problems (Seizures, migraines, etc)			
15. Psychological/emotional problems			
16. Chronic pain			
17. Significant family medical problems (Parents/Siblings)			
18. Drug/alcohol dependence or abuse			
19. Prior work related injury			
20. Recent international travel			
21. Other: ______________________________			

Seasonal/Environmental Allergies? ____

Do you smoke? Yes No How much? ______________________________ How long? ____________

Do you drink alcohol? Yes No How much? ______________________________ How long? ____________

Have you received medical treatment or prescription medication in the past 60 days? If so, give details____________________

____

Date of last Tetanus vaccine: ____________________________ Date of Last TB Test: ________________________

Past surgeries: ____

Women: Date of last PAP: _____________ Date of last Menstrual period: ____________

Are you pregnant? Yes No Could you be pregnant? Yes No

IF YOU DO NOT UNDERSTAND ANY OF THE ABOVE TERMS OR QUESTIONS, PLEASE ASK THE CLINICIAN TO CLARIFY

I certify that the information contained in this record is correct and complete to the best of my knowledge and belief. I understand that Champlain Valley Urgent Care will keep this medical information confidential.

Signature of Patient/Guardian: ____________________________________ Date: ______________

Medical History Update:	item # (s)	Details:	Patient Initials:	CVUC Staff Initials:
Date: _________				
Date: __________				