

Date: _____ Initials: _____

**Champlain Valley Urgent Care
7 Fayette Road South Burlington Vermont 05403**

Please print information clearly

Patient Information:

Name: _____ Male: _____ Female: _____
Date of Birth: _____ SSN: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Emergency Contact: _____
Cell Phone: _____ Emergency Contact Phone: _____
Email Address: _____ Occupation: _____

Employer Information:

Employer Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone: _____ Fax: _____
Contact Person: _____ Injury Verification: _____

Worker's Compensation Carrier:

Carrier Name: _____
Address: _____
Phone: _____ Fax: _____
Contact Person: _____

Injury Information:

Date of Injury: _____ Time of Injury: _____ AM PM
Place of injury: _____
Accident reported to employer? No Yes Name of person: _____
Give full description of how accident occurred: _____

Have you lost time from work? No Yes How much? _____
Have you seen other doctors for this condition? No Yes What was the diagnosis? _____
Were x-rays taken? No Yes
Other tests performed? No Yes
Previous worker's comp injury? No Yes Dates if previous injuries: _____
Please describe: _____

In the event that my Worker's Compensation Claim is denied by the insurance carrier, I understand that I am financially responsible for all charges in connection with the evaluation and treatment of this injury. We are able to bill some private health insurances in the event that your worker's compensation claim is denied. If you list no private insurance carrier, you will be billed directly.

I have private health insurance No Yes Insurance Name: _____

Please complete the reverse side of this page



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: _____

Signature updates:

Patients who are updating signatures are agreeing to consent for treatment, release of information, and financial policy statements of Champlain Valley Urgent Care, which are detailed above.

1. Patient/Guardian Signature: _____ Date: _____
2. Patient/Guardian Signature: _____ Date: _____

General Medical History

Patient Name: _____ **Date of Birth:** _____
Name of Primary Care Physician: _____ None

<u>Drug Allergies</u> _____ _____	<u>Current Medications</u> _____ _____
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Do you now have, or have you had in the past, any of the following? If yes, please give brief details.

<u>Condition</u>	<u>No</u>	<u>Yes</u>	<u>Details</u>
1. Skin problems			
2. Bleeding disorders			
3. Endocrine disorders (Diabetes, thyroid problems)			
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 or 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:** _____

<u>Medical History Update:</u>	<u>item # (s)</u>	<u>Details:</u>	<u>Patient Initials:</u>	<u>CVUC Staff Initials:</u>
Date: _____				
Date: _____				

Occupational Medical History

This physical examination is intended to verify your physical capability to perform the job for which you are being hired. This physical is **NOT** a substitute for your annual or biennial physical examination that you would have with your personal physician. If you are over 40 and do not have a primary care physician, you should establish yourself with one. If there are specific issues you would like to discuss today with the clinician, please let them know, or follow up with your primary care physician.

Patient Name: _____ Date of Birth: _____

Please check any of these items to which you have had exposures to or needed medical treatment following an exposure:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Asbestos | <input type="checkbox"/> Dust | <input type="checkbox"/> Vapors/Gases | <input type="checkbox"/> Electroplating |
| <input type="checkbox"/> Benzene | <input type="checkbox"/> Radiation | <input type="checkbox"/> Vibrations | <input type="checkbox"/> Hazardous waste |
| <input type="checkbox"/> Blood/Body Fluids | <input type="checkbox"/> PCB, PBB | <input type="checkbox"/> Heat/cold exposure | <input type="checkbox"/> Lead |
| <input type="checkbox"/> Cadmium | <input type="checkbox"/> Noise | <input type="checkbox"/> Pesticides | <input type="checkbox"/> Arsenic |
| <input type="checkbox"/> Mercury | <input type="checkbox"/> Methylene Chloride | <input type="checkbox"/> Sandblasting | <input type="checkbox"/> solvents |

Other: _____

If YES to any of the above, describe below including a complete description of the exposure, dates of occurrences and the names of physicians who treated you. Also, please list place of employment if exposure occurred in a work environment.

1. Have you ever been injured on the job in any way?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
2. Have you ever gotten sick in any way from something you worked with on the job?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
3. Has your work ever caused problems with your joints (wrists, hands, knees, etc.) your back or skin?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
4. Have you had any hobbies or jobs in which you use chemicals, metals, loud machines or tools, firearms, music amplifiers, or other hazardous substances?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
5. Have you ever claimed Worker's Compensation Benefits?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
6. Have you ever terminated any job for health reasons?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
7. Have you ever had to transfer from one job to another or change job duties for health reasons?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
8. Have you ever been refused any job for health reasons?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
9. Has a doctor ever placed restrictions on your lifting, bending, twisting, walking, standing sitting or using your hands, arms, or back?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
10. Have you ever had a back injury or experienced back pain or back strain?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
11. Have you ever had x-rays of your back?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
12. Have you ever had surgery of any kind?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
13. Have you ever been advised to have surgery that wasn't completed?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
14. Are you currently under work restrictions?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
15. Do you limit your personal activities due to pain, inability, or any other reason?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
16. Have you ever received instructions of proper lifting?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
17. Are you NOW under the care of anyone for a medical or health-related problem?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

If yes to any of the above, describe below including a complete description of the exposure, dates of occurrences, and name of physician who treated you.

If you do not understand any of the above terms or questions, please ask the clinician to clarify

I certify the information contained in this record is correct and complete to the best of my knowledge and belief. I understand that knowingly making a false statement in this record may have consequences such as denial of worker's compensation claims, withdrawal of offers of employment. I understand that Champlain Valley Urgent Care will keep this medical history confidential.

Signature of patient: X _____ Date: _____

Signature of clinician: _____ Date: _____

Medical History Update: (Indicate item #'s)	Details	Patient Initials	CVUC staff initials
Date: _____			
Date: _____			

CVUC Financial Policy Statement

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 Visa, MasterCard, and cash, 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 CVUC 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 CVUC'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 responsible party, if minor) Date

X _____
Please print the name of the patient



Please turn page over



Acknowledgement of Offer to Receive or Receipt of Notice of Privacy Practices

Your Personal Health Information is Kept Private by Champlain Valley Urgent Care

In accordance with the federal HIPPA 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.

I have been offered a copy of the Notice of Privacy Practices for **Champlain Valley Urgent Care**

Name of patient (please print neatly) **X** _____

Signature of Patient/Guardian **X** _____

Date **X** _____

Please turn page over

