Oakridge Urgent Care
Care at YOUR Convenience

201 S. Oakridge Drive
Hudson Oaks, TX 76087
817-599-5518 Main 817-599-5538 Fax
www.oakridgeurgentcare.com

REVIEWED BY _____ (INTERNAL)

Patient Intake Form

Please present your insurance card at time of check-in.
Settlement of patient financial responsibility is expected at time of service.

TYPE OF VISIT: ☐ INSURANCE (PRESENT CARD AT CHECK-IN) ☐ SELF-PAY (PAYMENT DUE AT TIME OF SERVICE)
TODAY'S DATE: _____

Patient Information:

Last: _____First: _____Middle Initial: _____

Date of Birth: _____Social Security Number: _____Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow Spouse Name: _____

Address: _____ City _____State ____ ZIP_____

Home Phone: _____Cell Phone: _____

Work Phone: _____Email:_____

**For Federal Government use:* Race: _____ Ethnicity: _____ Language:_____
☐ **Check here to refuse to provide this information**

Employer: _____ Employer Address: _____

Occupation: _____Employment Status: _____

Please state your reason for today's visit: _____

Are you experiencing any of the following? Please stop and notify attendant immediately.
☐ **SEVERE chest pains** ☐ **SEVERE shortness of breath** ☐ **Any other life-threatening condition**
☐ **Uncontrolled bleeding** ☐ **Allergic reaction**

Is this an on-the-job or other work-related injury? Yes ☐ No. *If Yes, we do not accept TX Work Comp.*

How did you hear about us?
☐ Drive-by/signage ☐ Insurance company directory ☐ Advertising (specify: _____)
☐ Physician referral (Name :_____) ☐ Friend/relative/co-worker

Physician Information
Who is your Primary Care Physician (PCP)? _____

Responsible Party Name: *Please complete if the patient is a minor and/or not responsible for charges.*

Last: _____First:_____ Middle Initial_____

Date of Birth: _____Social Security Number: _____Sex: ☐ M ☐ F

Address: _____City _____State _____ ZIP_____

Home Phone: _____ Cell Phone: _____Employer: _____

Patient Intake Form

Medical History:

List **ALL** medications and doses (including vitamins) that you are currently taking:

List any additional medical conditions you would like to notify or discuss with the physician:

List **ALL** known allergies & specific reactions:

Print Patient's Name: _____

PATIENT / RESPONSIBLE PARTY SIGNATURE _____DATE _____ /_____ /_____

Insurance Information:

Do you have primary and/or secondary insurance that should be billed?
□ Yes □ No. *If yes, please provide card(s) to registration desk. *If different from patient, please provide:*

***Policy Subscriber Name**: _____ Address: _____

DOB: _____ SSN: _____

Emergency Contact

Name: _____Phone:_____ Relation: _____

Pharmacy Information: *Please provide the pharmacy you would like your prescription sent to.*

Name: _____Address:_____

City: _____ State: _____ Zip: _____

Authorization and Release

Authorization For Treatment: I voluntarily consent to the administration and cost of medical and surgical procedures, x-ray, and medication for myself and my dependents.

Assignment of Insurance Benefits: I authorize payment directly to Oakridge Urgent Care for all benefits otherwise payable to me.

Guarantee of Payment: I understand that I am financially responsible and agree to pay all of the charges that are not paid or billed to insurance or any other third party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance copays, coinsurances, and deductibles today. If you are unable to verify my insurance at time of service, I will pay in full for all services.

Authorization For e-Med Hx: I authorize Oakridge Urgent Care to automatically download my medication and prescription history and I consent to the release of my vaccination records to the Texas State Registry.

Release of Records: I authorize Oakridge Urgent Care to release (verbal or in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or other health care operations which may be liable to me or my practitioner(s) for charges for this treatment and for quality management, utilization review, transfer, and follow-up purposes.

Receipt of Privacy Practices: I acknowledge that I have read the Notice of Privacy Practices of Oakridge Urgent Care.

I understand that a copy of this agreement may be used with the same effectiveness as the original.

Print Patient's Name: _____

Patient/Responsible Party Signature: _____Date ____/_____/_____

FINANCIAL POLICY

Thank you for choosing Oakridge Urgent Care as your minor emergency care provider. We are committed to providing you with quality medical care and believe that a good physician/patient relationship is based upon understanding and good communications. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

Insurance Coverage

It is your responsibility to:

- Provide proof of insurance. We must obtain a copy of your driver's license and current valid insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
- Be prepared to pay your copayment and/or deductibles at each visit. All copayments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copayment at each visit. Payment can be made by cash, debit, check or credit card. We will not be able to provide you service until copayment is made.
- Notify us of any changes in insurance coverage.

We do NOT accept Medicaid insurance. If Medicaid is your secondary insurance you will be responsible for any balance due after the primary insurance has paid. We will not file any claims to Medicaid.

Out-of Network Insurance

In today's environment, insurance carriers have created hosts of plan. Some of which have VERY narrow networks. We can inform you of major carriers and most plans we accept, but it is the burden of the patient to know the providers in their network. You will be financially responsible for any services rendered if it is determined we are out of network with your carrier/plan.

- Payment of unpaid balances on account is required at registration.
- Payment in full for visit charges is required at the time of service. Please be aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers.
- As a courtesy, our office will submit a claim to the out-of-network carrier; however, payment in full is expected at the time of service. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

No Insurance / Cash Pay Patient

- Payment of unpaid balances is required at registration.
- Payment in full for visit charges is required at the time of service.
- A cash discount is offered to cash pay patients.

Forms of Payment Accepted

- Cash, personal checks, and most major credit cards may be used for payment.

Financial Responsibility

- If the patient is a minor (18 years and younger), the parent or guardian must sign below. The parent, guardian or unaccompanied minor is responsible for any payment due at time of service, bringing the necessary insurance card.
- We are happy to help you with questions about your insurance. However, specific coverage issues should be directed to your insurance company member services department (number is on card).
- If you fail to make payment in full for the services that are rendered to you, your outstanding balance will be sent to a collections agency. You will be responsible for the fees assessed by the collections agency.
- Questions about financial arrangements should be directed to the billing office.

Disclaimer: Oakridge Urgent Care may refuse to treat patients who do not comply with these policies.

Waiver of Confidentiality: If account is processed by a third party collection agency or a record of past due status is reported to a credit bureau, a record of the patient's visit to Oakridge Urgent Care may become public record.

I have read and understand the Financial Policy and agree to abide by its guidelines.

Print Patient's Name Date

Signature of Patient or Responsible Party Date

Signature of Co-Responsible Party Date

Oakridge Urgent Care

Care at YOUR Convenience

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION AND RELEASE FORM

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Oakridge Urgent Care. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PROTECTED HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE AND AS AUTHORIZATION FOR RELEASE OF MY VACCINATION RECORD TO THE TEXAS STATE REGISTRY.**

_____ _____

Please **print** patients name ***Patient Signature*** (Guardian sign if patient under 18)

_____ _____

Print Guardian name (If patient under 18) Relation to patient

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR MEDICAL INFORMATION
(This includes spouse, step parents, aunts, uncles & any caretakers who can have access to this patient's records.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE **TO CONFIRM MY APPOINTMENTS, TREATMENTS & BILLING INFORMATION** VIA:

- ☐ Cell Phone Confirmation please provide number: _____
- ☐ Home Phone Confirmation please provide number: _____
- ☐ Work Phone Confirmation please provide number: _____
- ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** TO BE CONVEYED VIA:

- ☐ Message on Cell Phone please provide number: _____
- ☐ Message on Home Phone please provide number: _____
- ☐ Message on Work Phone please provide number: _____
- ☐ U.S Mail/ Postcard
- ☐ **Any of the above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES OR EVENTS** VIA:

- ☐ Phone Message
- ☐ Email please provide email: _____
- ☐ U.S Mail/ Postcard
- ☐ **Any of the Above**