Hope Urgent Care Clinic
Patient Registration

(PLEASE WRITE LEGIBLY & COMPLETE ALL BLANKS, OR THIS MAY INCREASE YOUR WAIT TIME)

PAYMENT IS DUE BEFORE SERVICES ARE RENDERED!

Physician: _____ Today's Date _____

*STAR INDICATES REQUIRED INFORMATION

Section A: Patient Information

*Patient's Legal Name First _____ MI _____ *Last _____

*Address _____ *City _____ *St _____ *Zip _____

Please include apartment/unit/suite number*

*Telephone (H) _____ (C) _____ *Date of Birth _____ *Sex F M

Marital Status _____ Social Security Number _____ Driver's License _____

Email address: _____

Employer's Name _____ Telephone _____

Address _____ City _____ St _____ Zip _____

*Emergency Contact Name _____ Phone _____ Relation _____

Section B: IF CHILD IS UNDER 18- Parent / Guardian Information:

*STAR INDICATES REQUIRED INFORMATION

*Guardian's Legal Name First _____ MI _____ *Last _____

*Address _____ *City _____ *St _____ *Zip _____

*Telephone (H) _____ SS# _____ *Date of Birth _____

Cell _____ *Patient's Relationship to you: (circle one) Self Spouse Child Other _____

Email address: _____

Employer's Name _____ Employer's Telephone _____

Employer's Address _____ City _____ St _____ Zip _____

If lab work is being done, please present you insurance card to the receptionist so we can grab a copy.
Thank you!!

***HOW DID YOU HEAR ABOUT US? _____ ***

Patient Name_____ Date of Birth_____

Notice of Privacy Practices

_____ (Initials) **Acknowledgement of Receipt of Privacy Practices**

I have been presented with a copy of Hope Urgent Care Clinic's Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, outlining my rights regarding my health information.

Authorization for Release of Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only allow us to give information to family members indicated below.

I authorize Hope Urgent Care Clinic to release the following information to the individual(s) listed below (**please check information you wished to be released**):

_____ (Initials) **If you do not wish to release information to anyone, please initial here.**

( ) Complete Medical/Billing Records ( ) Lab Results ( ) Immunization Records ( ) X-Ray Results
( ) Billing Records Only ( ) Other (specify):_____

1._____ Relation to Patient: _____

2._____ Relation to Patient: _____

3._____ Relation to Patient: _____

I understand I have the right to revoke this authorization at any time and that I have the right to know what protected health information is to be disclosed. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

Signature:_____**Date:**_____

Staff Signature:_____ **Date:** _____

HOPE
URGENT CARE
CLINIC

HOPE URGENT CARE CLINIC

NAME:_____

DATE:_____

Have you traveled outside the country in the last 30 days?

YES____ NO____

Have you been around anyone that has been outside the country in the last 30 days?

YES____ NO____

Have you been exposed to anyone that could potentially have the COVID 19?

YES____NO___

Do you have any of the Following symptoms;

Fever: Yes_____ No_____

Cough: Yes_____ No_____

Shortness of Breath: Yes_____ No_____

***If so Please Ask for a Face Mask**

*****We Do Not Test for the Coronavirus.**

Coronavirus Document for Denial of Exposure, Symptoms and Denial of Travel

March 23, 2020

If you have traveled from an affected area, there may be restrictions on your movements for up to 2-4 weeks. If you develop symptoms during that period (fever, cough, sore throat, trouble breathing and nausea/vomiting/diarrhea), seek medical advice. Call the office of your health care provider before you go, and tell them about your travel and your symptoms. They will give you instructions on how to get care without exposing other people to your illness. While sick, avoid contact with people, don't go out and delay any travel to reduce the possibility of spreading illness to others. Please initial the following:

1) I swear I have not traveled to Coronavirus affected areas and have not been exposed to Coronavirus to my knowledge_____
2) I swear I do not have a fever, cough, sore throat, trouble breathing, N/V/D or any symptoms of Corornavirus and have not been tested Positive for Coronavirus _____
3) I swear none of my family members/ friends or co-workers have been tested positive for the Coronavirus _____
4) I swear I have not tried to get tested for Coronavirus due to positive symptoms:_____

I have been informed I could be lawfully/legally held responsible for infecting employees and patients at Hope Urgent Care Clinic if I haven't been truthful concerning the above questions.

Signature: _____

Date: _____