Urgent Care Center of Bloomfield PLLC	DATE	NEW ❑ UPDATE ❑
PRIMARY CARE PROVIDER	PHARMACY NAME	
REFERRED BY	PHARMACY PHONE	

PATIENT INFORMATION

LAST	FIRST	MI.	BIRTHDATE	Marital Status

Gender Identity	❑ M	❑ F	❑ Non-Binary	❑ Other	❑ TransGen F	❑ Transgen M	❑ Choose not to disclose
Sex at Birth	❑ M	❑ F	❑ Intersex	❑ Uncertain	❑ Unknown	❑ Choose not to disclose	

ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE
CELL PHONE	EMAIL ADDRESS

PATIENT SOCIAL SECURITY #	Preferred Contact Phone

RACE ❑ AMERINDIAN ❑ BLACK ❑ HISPANIC ❑ ASIAN ❑ WHITE

ETHNICITY ❑ HISPANIC ❑ NON-HISPANIC	PREFERRED LANGUAGE:

EMPLOYER/SCHOOL	OCCUPATION

EMPLOYER'S ADDRESS	CITY	STATE	ZIP	START DATE

NEXT OF KIN/EMERGENCY CONTACT (PERSON NOT LIVING WITH YOU) RELATIONSHIP PHONE

PARENT/GUARANTOR INFORMATION- PERSON FINANCIALLY RESPONSIBLE FOR BILL

LAST	FIRST	MI.	❑ PARENT (IF PATIENT A MINOR) ❑ SPOUSE ❑ OTHER _____	BIRTHDATE

ADDRESS (IF DIFFERENT FROM PT.)	CITY	STATE	ZIP	SOCIAL SECURITY #

HOME PHONE	WORK PHONE	CELL PHONE	EMAIL ADDRESS

EMPLOYER/SCHOOL	OCCUPATION

EMPLOYER'S ADDRESS	CITY	STATE	ZIP	START DATE

INSURANCE INFORMATION

Please complete all information to ensure accuracy in claim submission

INSURANCE COMPANY #1	POLICY/MEMBER ID #	GROUP #	COPAYS SPEC · $ PRIM · $

POLICY HOLDER	ADDRESS (IF DIFFERENT)	SSN	RELATION TO INSURED ❑ SELF ❑ SPOUSE

DOB	CITY	ST	ZIP	❑ CHILD ❑ OTHER

INSURANCE COMPANY #2	POLICY/MEMBER ID #	GROUP #	COPAYS SPEC · $ PRIM · $

POLICY HOLDER	ADDRESS (IF DIFFERENT)	SSN	RELATION TO INSURED ❑ SELF ❑ SPOUSE

DOB	CITY	ST	ZIP	❑ CHILD ❑ OTHER

INJURY INFORMATION

IS INJURY ❑ WORK RELATED ❑ AUTO RELATED CLAIM #_____ DATE OF INJURY / /

I, THE PATIENT OR GUARANTOR, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE. I ACCEPT RESPONSIBILITY FOR THE MEDICAL CHARGES INCURRED BY THE PATIENT AND AGREE TO PAY ALL BILLS AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. I AUTHORIZE PHYSICIAN AND PRACTICE TO RELEASE ANY INFORMATION TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE MY INSURANCE CLAIMS TO BE PAID DIRECTLY TO THE PRACTICE OR ITS REPRESENTATIVE. I UNDERSTAND THAT ALL SERVICES NOT COVERED BY MY INSURANCE WILL BE MY RESPONSIBILITY.

PATIENT/GUARANTOR SIGNATURE _____ ***DATE*** _____

(PARENT IF PATIENT IS A MINOR)

URGENT CARE CENTER

Name: _____ Date of Birth: ___/___/___
Today's Date: _____
Reason for Visit: _____
Current Medications:

_____
_____
_____

Allergies: None / Yes
If yes, please list: _____
Medical History: (Circle if yes)
High Blood Pressure, High Cholesterol, Heart Disease, Diabetes, Asthma, Depression, Acid Reflux, Thyroid Disease, Cancer (if yes, which type) _____
Other: _____
Have you had the Corona Vaccine? Yes / No

Past Surgical History:

_____
_____

Family History:
High Blood Pressure, High Cholesterol, Heart Disease, Diabetes, Asthma, Depression, Acid Reflux, Thyroid Disease, Cancer (if yes, which type) _____
Other: _____

Occupation:
Alcohol:
Race:
Smoking:
Substance Abuse:

Do you have any symptoms?

	Fever		Flu-like symptoms		Headache
	Muscle Pain		Vomiting		Diarrhea
	Abdominal Pain		Unexplained Bleeding		None of the above

Within the last 30 days, have you traveled to/from out of state or out of the country? If so where?

_____

Have you been in contact with a person known or suspected of having the Corona virus? Yes / No

Patient/Guardian Signature: _____ Date: ___/___/___

Reviewed (MD Signature): _____

THE URGENT CARE CENTER

Financial Policy

Whenever possible, we will verify your copayment, deductible and coinsurance status at the time of your visit. All estimated patient cost shares will be due and payable at the time services are rendered. Your claim will be submitted to your insurance if the information is provided to us at the time services are rendered. You will be billed for any remaining balances after the claim is processed. Payment is expected within 30 days.

If you present without your insurance card or do not have insurance, payment in full is expected at the time of your visit. If you provide your insurance at a later date, you may be eligible for a refund. Many insurance companies have short filing limits. Claims may be submitted for consideration if the filing limit has not been exceeded.

Subsequent visits—all patient responsible balances for previous services must be paid in full. If you have an outstanding balance, it will be collected prior to being seen.

We are participating with many, but not all plans and networks. Your claim may be processed under your out of network benefit.
Most insurance carriers view us as a private physician's office. If your insurance requires that you select a primary care physician, example—***HMO plans (see examples below) it is your responsibility to contact your insurance company for a referral or authorization within 24 business hours after the service is provided. If you are unsure, it is best for you to call your insurance and inquire.

Anthem, Cigna and Connecticare contract with us as a Walk In. Anything considered preventive is a non-covered benefit (example-physicals, immunizations, TB skin testing) and payment must be made at the time of service.

We accept cash, checks, Mastercard, Visa, Discover, American Express.

I understand and agree to the above policy

_____

Patient Name (Please print)

_____ _____

Responsible Party (Please Print) Relationship to patient

_____ _____

Signature Date

***Example of some plans that may require authorization. Aetna HMO, Tricare HMO/ Tricare Point of Service, Evercare Medicare. Obtaining authorizations is the patient's responsibility.

HIPAA ACKNOWLEDGEMENT FORM

Patient Name: _____ D.O. B _____

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights and describing your rights under the law. You establish that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature and date it. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. By signing this form, I understand that: Protected health information may be disclosed or used for treatment, payment, or healthcare operations. The practice reserves the right to change the privacy policy as allowed by law.

I, _____ (your name) acknowledge receipt of the HIPAA privacy notice that is required by law. I hereby authorize, Dr. Ramirez Medical practice and/ or the Urgent Care Center of Bloomfield to disclose and use information for treatment, payment, or healthcare operations.

Signature: _____ Date: _____

Relationship to patient if other than self: _____

If you expect that you will need or want your medical information to be provided to family members, friends, caretakers/babysitters, please indicate that below. If you do not want any of your medical information provided to anyone, please check the decline box or fill out the line where you want to remove someone from communication. By signing below, you authorize the following people to receive information regarding your treatment or care: You can always add names or updated changes to this form by notifying our staff. Please list the name, relationship, and phone number of the person you want authorized for us to disclose medical information regarding your treatment to.

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____