Express HEALTH Clinic – Patient Information Form

Ver 60.0

Date	New Patient: YES NO	Acct #	Insurance:	Self-Pay

****NOTE- If you have a condition that is outside this clinic's offered services, you may be referred elsewhere for further evaluation.**

****NOTE- It is important that you read the signage posted in the clinic for additional information related to your visit to our clinic.**

SECTION 1 PATIENT INFORMATION

Patient Full Legal Name (First) (Middle) (Last)	Date of Birth	SSN	Sex Male Female

Address (Number) (Street) (Apt. No.)

City	State	Zip	Email

Phone (Home)	Phone (Cell)

Primary Care Physician	Marital Status	Employment Status	Student Status

Emergency Contact Name ('ER Contact')	Relationship:	Contact Phone	Circle information that may be shared with ER Contact: All Medical Financial None

Other Adults allowed to bring minor child for treatment:	Do you consent for the minor to receive Injections: YES NO

Have you Executed an Advanced Directive such as "Living Will" or Power of Attorney? NO YES – Please provide a copy

SECTION 2: REASON FOR VISIT – Check Each Box That Applies

Illness/Injury/Other: Please indicate your "Chief Complaint" and check any symptom below that relates

Chief Complaint:		**When did Problem Start:**
Sinus Congestion/Pain	*Ear Problems*	*Fatigue*
Postnasal Drip	*Eye problems*	*Dizziness*
Yellow or green mucous	*Headache*	*Poor Appetite*
Cough	*Nausea*	*Muscle/joint pain*
Wheezing/Short of Breath	*Vomiting*	*Skin condition/rash*
Sore Throat	*Diarrhea*	*Urinary Symptoms*
Fever	*Constipation*	*Jaw/Tooth/Gum Pain*
Other:		

Physical Exam Services - Sports School Work Other	Bill to:
Drug Screen Services - DOT Employment Other	Bill to:

SECTION 3: MEDICAL HISTORY – Conditions you have or have had in the past – check all that apply

High Blood Pressure	Allergies/"Hay Fever"	Diabetes	Cancer	Prostate enlargement
Heart Attack	Frequent Ear/Sinus Infect	Kidney Disease	Stroke	Glaucoma
Heart Disease	GERD	Liver Disease	Seizures	Depression/Anxiety
Heart Murmur	Asthma	High Cholesterol	Emphysema/COPD	Low Thyroid

Other:	**Last Menstrual Period:**

Current Medications
None Yes – list:

Medical Allergies
None Yes – list:

Hospitalizations *(include dates)*:

Surgeries (*include dates*):

Smoking Status: No Prev Yes: # Packs/Day: X # Years: Second Hand Smoke exposure: No Yes	**Alcohol Use:** No Yes: # Drinks/Week:	**Recreational Drug Use:** No Yes: List:

Have you had any steroids, injected or oral, in the in the last 30 days? No Yes - *Dates:*

Have you traveled outside of the united states in the in the last 30 days? No Yes - *Dates:*

Reviewed By: ,FNP

PLEASE NOTE *Strep Tests will not be valid if you have had food, drink, gum, lozenges or cigarettes within 15 minutes before test.*

COMPLETE SIDE 2

SECTION 4: FINANCIAL RESPONSIBILITY

The Following Responsible Party is the "Guarantor" and is responsible for the cost of services to the Patient:

Full Legal Name	Date of Birth:	Social Security No		Relationship to Patient	
Address (if different than Patient):	City	State	Zip	Phone (Home)	Phone (Cell)

Primary Insurance: *Please provide card to be scanned*

Primary Insurance:		ID#	Group#
Subscriber Full Legal Name		Date of Birth	Social Security Number
OFFICE USE:	*Processed:*	*Eligibility ID:*	*PCC:*

Secondary Insurance: *Please provide card to be scanned*

Secondary Insurance:		ID#	Group#
Subscriber Full Legal Name		Date of Birth	Social Security Number
OFFICE USE:	*Processed:*	*Eligibility ID:*	*PCC:*

Tertiary Insurance: *Please provide card to be scanned*

Secondary Insurance:		ID#	Group#
Subscriber Full Legal Name		Date of Birth	Social Security Number
OFFICE USE:	*Processed:*	*Eligibility ID:*	*PCC:*

SECTION 5: ACCEPTING INSURANCE, RELEASES AND CONSENTS

✓ **We contractually participate with many of the major insurance plans in this area** and those plans or insurance companies are identified on **our** signage. **However, we do not Accept Assignment of all insurance plans**. Before service is rendered, **you** should confirm with **our** staff (i) **our** policy regarding **your** insurance plan(s) and (ii) **your** Financial Responsibility. **We** also want **you** to know that:

- **You** are responsible for the balance pursuant to **your** plan; such as required co-pay, coinsurance, deductible and non-covered charges.
- Money collected at the time of service is an estimate of **your** Financial Responsibility. Actual benefits are not determined until the insurance company has processed your claim. You may receive a bill for additional amounts owed
- If **we do not participate in your plan's network and do not Accept Assignment of your insurance plan:**
  - **We** must receive payment in full by **you** at the time of service. However, we can provide **you** with information that will help **you** file for reimbursement by **your** insurance plan

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ExpressHealth Clinic Corporation ("EHC")

Patient Name (Please print full name):____

<u>I. Consent for Treatment</u>. I understand that **EHC** Family Nurse Practitioners (FNPs) only test for & treat a limited number of common family illnesses & conditions, **EHC** FNPs do not follow up with patients after visit discharge & have no means to access patient's previous health records. It is my obligation to disclose all health related medical history, current medications & allergies to the **EHC** FNP. I have accurately completed the questions & information on the reverse side of this form. If I have questions regarding any other health condition except for the reason for today's visit with EHC, I will present them to my (or the patient's) regular health care provider & I understand that I will need to follow up with my (or the patient's) regular health care provider. I hereby consent to the test(s), assessment(s) &/or treatment(s) to be performed as recommended by the **EHC** health care provider.

<u>II. Release of Medical Records & EHC Privacy Practices.</u> I hereby authorize the release of medical information about the person named above to (1) all insurance companies & their intermediaries as needed for the claim reimbursement to **EHC**, & (2) to other health care providers who may participate in the treatment of that person.

<u>III. EHC Privacy Practices</u>. **EHC** has made available to me a copy of its privacy practices and I understand & approve those practices.

<u>IV. Insurance Benefits.</u> I have read & understand **EHC**'s Policies for Financial Responsibility & Accepting Assignment of Insurance, & I desire that **EHC** accept assignment of available related insurance benefits as described in those Policies. I hereby assign to **EHC** the rights for payment of benefits under health insurance policies/plans for services rendered & EHC Accepted Assignment. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as an original.

<u>V. Acknowledgment of Responsible Party.</u> I am the Responsible Party with regard to the Patient & have the right & authority to execute this document & be bound by its terms as the Patient, the Patient's Parent/Legal Guardian, or otherwise as the Patient's Responsible Party. The Financial Responsibility for any payments that may be owed to **EHC** is my responsibility.

By signing below, I confirm that I have read (or have had explained to me), understand & agree to the statements herein:

Signed By:____Date:______________________________

Check One: I am the Patient Patient's Parent/Legal Guardian Patient's Responsible Party

If patient is unaccompanied minor, at least 16 or 17 years of age:

Verbal Consent given by:____________________________ _______________ _______________ **Date:**__________________ **PCC:**___________

Parent / Legal Guardian *Relationship* *Phone #*