



## PATIENT INFORMATION FORM

Patient Name			Social Security Number		
Date of Birth	Marital Status S M D W P		Address		
Home Phone	OK to leave message? Yes No		City	State	Zip
Email address			Employer's Name/Occupation		
Mobile Phone or Pager			Work Phone	OK to leave message? Yes No	
Emergency Contact		Relationship		Emergency Contact Phone	
Primary Care Physician			<b>Insurance</b>		
Pharmacy with two cross streets			Name of Insurance Co _____		
How were you referred to our practice? <input type="checkbox"/> Newspaper <input type="checkbox"/> Friend <input type="checkbox"/> Internet <input type="checkbox"/> Sign/Drive By <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other _____			ID # _____		
			Group # _____		
			Phone# _____		

## Insured and/or Parent/Guardian Information

Insured's Name		Social Security Number	
Date of Birth	Relationship to patient	Address (if different from above)	
Home Phone		City	State Zip
Work Phone	Employer's Name		

### Benefits Assignment

I hereby authorize the assignment of benefits (payments) directly to Excel Urgent Care for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance

Signature of Responsible Party: \_\_\_\_\_ Date \_\_\_\_\_

### Records Release

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature of Responsible Party: \_\_\_\_\_ Date \_\_\_\_\_



## **PATIENT FINANCIAL POLICY SHEET**

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept cash and the following major credit cards: VISA and MasterCard.

**Cash paying patients are required to pay a \$120 deposit prior to being seen which will be applied to your office visit.**

### ***Your Insurance***

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service.
- In the event we cannot verify your insurance benefits while you are in our office or if you have insurance coverage with a plan for which we do not have a prior arrangement . We will expect payment in full at the time of service.
- By signing this form you authorize us to bill your credit/debit card for any balance that your insurance company does not cover or deems to be your responsibility. We do not send out statements. A receipt will be mailed to you and your credit/debit card information will be shredded.

### ***Minor Patients***

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time. In the event the account must be placed with an attorney or collection agency to obtain payment, I shall be responsible for all attorney and collection agency fees incurred

\_\_\_\_\_  
Printed Name of the Patient

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Date



## **ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES**

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority

You have my permission to discuss my medical care/account with:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship





## COMPREHENSIVE REVIEW OF SYMPTOMS

Please fill in **YES** circles that apply to you **today**

### Genitourinary female

- Painful menstrual cycle  Yes  
Pelvic pain  Yes  
Irregular periods  Yes  
Vaginal itching  Yes  
Abnormal vaginal discharge  Yes

### Musculoskeletal

- Joint stiffness  Yes  
Joint pain  Yes  
Joint swelling  Yes  
Back pain  Yes  
Neck pain  Yes  
Muscle aches  Yes

### Constitutional

- Loss of appetite  Yes  
Fever  Yes  
Weakness  Yes

### ENT

- Nose bleeds  Yes  
Sore throat  Yes  
Ear pain  Yes

### Cardiology

- Palpitations  Yes  
Chest pain  Yes

### Gastroenterology

- Diarrhea  Yes  
Vomiting  Yes  
Constipation  Yes  
Nausea  Yes  
Abdominal pain  Yes

### Dermatology

- Itching  Yes

### Endocrinology

- Excessive thirst  Yes  
Excessive sweat  Yes  
Cold intolerance  Yes  
Heat intolerance  Yes

### Neurology

- Headache  Yes  
Tingling/numbness  Yes  
Dizziness  Yes

### Ophthalmology

- Drainage from eyes  Yes  
Blurring of vision  Yes  
Eye irritation  Yes

### Respiratory

- Shortness of breath  Yes  
Cough  Yes  
Congestion  Yes

### Allergy

- Runny nose  Yes  
Itchy eyes  Yes  
Sneezing  Yes

### Hematology/lymph

- Swollen glands  Yes  
Fatigue  Yes

### Urology

- Difficulty urinating  Yes  
Blood in urine  Yes  
Frequent urination  Yes  
Urinary incontinence  Yes

Other \_\_\_\_\_

Name \_\_\_\_\_

DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_