OUCH! URGENT CARE

6020 Meadowridge Center Dr.
Suite F
Elkridge, MD 21075
443-776-3031

Patient Name	Preferred Name	Social Security #	Date of Birth

Patient Street Address	City, State, Zip

Email address	Primary Care Physician Name and Location

Sex	Marital Status	OK to leave voicemail?
M F	S M W D	Home phone _____-_____-_____ Y N Cell phone _____-_____-_____ Y N

How did you hear about us? (check all that apply)

❑ Drove By ❑ Google ❑ Yelp ❑ Bing ❑ Friend ❑ Relative
❑ Dr. Referral ❑ School ❑ Insurance Referral ❑Other_____

Name and Location of Preferred Pharmacy	Reason for Your Visit Today
Policy Holder's Name/Relationship to Patient	**Policy Holder's Date of Birth**

Is this a Workers Comp or Car accident injury? (circle) Work Comp Car Accident		Employer/Insurance name	
Claim #	Date of injury/accident	Contact Name	Contact Phone

Employer/Insurance address	Any additional information

OVER

Please take this sheet to the desk when you are finished

OUCH! URGENT CARE

ALL information is **strictly confidential** and will become part of your medical record.

Name_____ **Date** _____

What brings you to OUCH today? _____

When did these symptoms start? _____

Are you having any pain? (circle) **Y** or **N** If yes, where is your pain?_____

On a scale of 0 (no pain) and 10 (worst pain you've ever had), what is your pain level now? _____

What makes your pain better? _____What makes your pain worse? _____

Describe your pain (circle all that apply) Sharp Stabbing Dull Ache Burning Tingling Tight Pressure Squeezing Pounding

Please list any known allergies and reactions or check ❑ if no known food/drug allergies.

Name_____ Reaction_____ Name_____ Reaction_____

Name_____ Reaction_____ Name_____ Reaction_____

Please list all current medications including prescribed, over the counter and supplements. ❑ NONE

Name_____ Dose_____ How often?_____

Name_____ Dose_____ How often?_____

Name_____ Dose_____ How often?_____

Name_____ Dose_____ How often?_____

Name_____ Dose_____ How often?_____

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Name_____ Dose_____ How often?_____

Name_____ Dose_____ How often?_____

Please list any medical problems such as high blood pressure, diabetes, cancer, high cholesterol, etc.

❑ NONE

_____

_____

Please list any prior surgeries and approximate date performed. ❑ NONE

Surgery_____ Date_____ Surgery_____ Date_____

Surgery_____ Date_____ Surgery_____ Date_____

Personal Health Habits and Personal Safety

Tobacco use?	Exposure to Secondhand smoke?	Do you drink alcohol?	Do you use illegal/illicit drugs?
Yes No	**Yes No**	**Yes No**	**Yes No**
If yes, # of packs/day?		**❑None ❑Rarely ❑Socially ❑Daily**	**If yes, which drugs do you use?**
I quit! Year you quit?		# drinks/week?	Are you in recovery? **Yes No**

☐ *Adopted*

Family Health History

Relationship	Age	Alive or deceased	Significant Health Problems	No problems
Father				
Mother				
Paternal Grandfather				
Paternal Grandmother				
Maternal Grandfather				
Maternal Grandmother				
Male Siblings				
Female Siblings				
Male Children				
Female Children				

Immunizations ☐ *Up to date*

Tetanus (TdaP or Td?)- Year_____ Flu Shot- Year_____ Pneumonia- Year_____

Would you like to discuss vaccination options today? Yes____ No____

Adult Medical Information Release Form (please answer all questions)

(You do NOT need to fill out this section for Patient UNDER 18 -PLEASE proceed to next section)

Name:_____ Date of Birth_____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Name_____ Relationship_____ Phone_____

Name_____Relationship_____ Phone_____

_____Do not release my information to anyone

The ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call: ☐ My home ☐ My work ☐ My cell phone _____If unable to reach me:

- ☐ You **may** leave a detailed message
- ☐ Please leave a message asking me to return your call
- ☐ Other_____

Patient Receipt of HIPAA Privacy Notice

Dear Patient,

OUCH Urgent Care is committed to maintaining the integrity of your protected health information and complies with all applicable state and federal regulations.

The federal privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA) have taken effect April 14, 2003. In support of our policy of complying with all applicable regulations, OUCH Urgent Care provides patients the HIPAA Notice of Privacy Rights.

While not required in order to receive treatment at OUCH Urgent Care, we are obligated under federal regulations to ask that you sign an acknowledgement of the HIPAA Privacy Notice being made available to you.

Thank you.

Receipt of HIPAA Privacy Notice

I acknowledge the receipt of the Notice of Privacy Rights with detailed information about how OUCH Urgent Care may use and disclose my protected health information. I understand that OUCH Urgent Care reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

Print Patient Name_____

Patient/Guardian Signature_____ Date_____

Office use only: To be completed only when a patient declined to sign acknowledgement. To be filed in the patient's record

☐ Check here if patient declined to sign acknowledgement

Staff Signature_____ (***Refusal to sign acknowledgement does not prevent the patient from continuing to be treated.)***

Patient Consent

I, the undersigned, hereby consent to the following treatment:

Administration and performance of all treatments. Administration of any needed anesthetics. Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient. Use of prescribed medication. Performance of diagnostic procedures, tests and/or cultures. Performance of other medically accepted laboratory test that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designee.

- ✓ I fully understand that this is given in advance of any specific diagnosis or treatment.
- ✓ I intend this consent to be continuing in nature even after specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.
- ✓ I understand the OUCH Urgent Care may include consent at satellite offices under common ownership.
- ✓ I, the undersigned, acknowledge that OUCH Urgent Care will use and disclose my information for the purposes of treatment, payment and healthcare operations.
- ✓ A photocopy of this consent shall be considered as valid as the original.
- ✓ ***Medicare Patients***: I authorize to release medical information about me to the Social Security Administration or it's intermediates for my Medicare claims. I assign the benefits payable for services to OUCH Urgent Care, LLC.
- ✓ I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Financial Responsibility

Thank you for choosing OUCH Urgent Care for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:
The patient (or patient's guardian, if a minor) is ultimately responsible for the payment and treatment and care.
We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
Copays are due at the time of service.
Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.
Patients may incur, and are responsible for payment of additional charges, if applicable. These charges include:

- ✓ Charge for returned checks of $35.00

You may become responsible for the medical costs of treatment for your illness or condition the provider listed below of (1) you fail to pursue the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result or a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment /services performed after the date the agreement is approved. if any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered. You expressly consent and agree that, in order to discuss or service your accounts(s) (the "Accounts ") or to collect amounts you may owe OUCH, and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively, "We") may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contact you by sending text messages, emails, using any e-mail address you provide to us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

By my signature below, I hereby authorize assignment of financial benefits directly to OUCH Urgent Care and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Patient Name_____ Date of Birth_____

Patient/Guardian Signature_____ Today's Date_____

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