Patient Registration

Patient Last Name ____________________ Middle Initial _______ Patient First Name ______________________________

Race (circle): American Indian Alaska Native Black or African American Asian White

Native Hawaiian/Other Pacific Islander Other _______________

Preferred Language _________________________________ Ethnicity (circle): Hispanic or Latino Not Hispanic or Latino

E-mail ___________________ Gender M____ F_____ Employer (if applicable) ____________________________________

Social Security Number _______________________________________ Date of Birth _______________________________

Mailing Address ____

City ____State _____________________ Zip ________________________

Home Phone _____________________________________ Cell Phone ____

Primary Care Physician _______________________________ Pharmacy ____

Emergency Contact Name _____________________ Emergency Contact # _________________ Relation: ______________

Insurance ☐ Self Pay ☐

What are we seeing you for? ____

•••••••••••••••••••• **Primary policyholder, guarantor and patients under 18**••••••••••••••••••••

Policyholder/Guarantor Name ____

Policyholder/Guarantor Contact # ______________________ Address ____

City ________________________ State _________ Zip _____________________

Policyholder/Guarantor SSN _____________________________ Date of Birth ______________________________________

Relationship to Patient ____

••••••••••••••••••••••• **Secondary policyholder**•••••••••••••••••••••••

Policyholder/Guarantor Name ____

Policyholder/Guarantor Contact # _____________________ Address ____

City ___________________________ State _______ Zip _____________________

Policyholder/Guarantor SSN ________________________________ Date of Birth _____________________________________

Relationship to Patient ____

Authorization For Care & Treatment I 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 tests that may be considered medically necessary or advisable based on the judgment of the attending provider. 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 a specific diagnosis has been made and treatment recommended. I agree to provide accurate and thorough information regarding my medical history and any conditions or events that may impact medical decisions. This consent will remain in full force until revoked in writing.

HIPAA Acknowledgment I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, Obtain payment from third-party payers. Conduct normal healthcare operations such as quality assessments and physician certifications. I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Release of Information and referrals I, the undersigned, acknowledge and give permission to Grand Ave Urgent Care (GAUC) to disclose my healthcare information for the purposes of further treatment, payment, and healthcare operations. A photocopy of this consent shall be considered as valid as the original.

Insured Patients GAUC does participate with numerous insurance companies. Co-payments, co-insurances and/or non-covered services are required to be paid by you in full at the time of service. Insurance contracts state the balance and co-payments cannot be waived. Such insurance may include, but is limited to, private commercial insurance, auto insurance, workers compensation, Medicare and Tricare. There are some insurance carriers with which we do not have a contract. I will be responsible for the entirety of the cost of services and considered an uninsured patient. I certify that the information given regarding my insurance is accurate and current to the best of my knowledge. If a claim is denied by insurance because I did not provide the correct insurance information or respond to any information requests in a timely manner, I understand that I will be financially responsible for any and all treatment(s) received.

Uninsured Patients Payment is due at the time of service at the current self-pay rate. I will be responsible for services rendered at an uninsured discount for the visit, procedures and other medical services.

Disclosure of Ownership Interest GAUC is wholly owned by John Jacobs, N.P. Because the provider owns the practice, he is best able to ensure the highest level of care is provided.

Notice of Separate Billing: The provider may order laboratory and/or other radiology services for you while you are in our facility. We do not bill for any services sent out to another facility. If you have any questions pertaining to your third-party lab or radiology bill, please contact their billing office as we are not their billing department.

Collections I understand that if my account is not paid in full, my account will be turned over to a third-party collection company for further processing and I will be responsible for paying any collection fee incurred by the practice. Any such fees will be added to the outstanding balance owed. No additional appointments will be made for delinquent accounts until they are brought current.

Occ Med Patients Payment for services rendered at GAUC for Occupational Health Medicine will be the responsibility of the company for whom I am employed. I am responsible for any services provided but not covered by my employer.

I give permission for GAUC to discuss any health-related issues with the following individual(s):

____

Patient Name: ____

Relationship to Patient: Self Mother Father Grandparent Guardian Other_______

Patient / Guardian Signature: ______________________________ **Date:** ______________________________

GRAND AVE URGENT CARE

3236 Grand Ave. Suite D
Laramie, Wyoming 82070
P: (307) 760-8602
F: (307) 460-9880
Email: info@grandaveurgentcare.com
Website: grandaveurgentcare.com

Your Rights

The Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operation. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction you may request. If your provider believes it is in you best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request confidential communications from us by alternative means or to an alternative location. You have the right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this Notice alternatively (i.e. electronically).

You may have the right to have your provider amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this Notice and will inform you of any changes.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint at our office and main telephone number. We will not retaliate against you for filing the complaint.

This Notice was published and becomes effective on/or before 07/11/2016

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Uses and Disclosures of Protected Health Information

Your Protected Health Information may be used and disclosed by your provider, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operations of the practice, and any other use required by law.

Treatment: We will use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a provider to whom you have been referred to ensure that the health care professional has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, and conducting or arranging for other business activities. We may use or disclose, as needed, your protected health information to support the business activities of this practice. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or call your home and leave a message (either on an answering machine or with the person answering the phone) to remind you of an upcoming appointment, the need to schedule a new appointment or to call our office. If you would prefer that we call or contact you at another telephone number or location, please let us know.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: As Required By Law, Public Health issues Required By Law, Communicable Diseases: Health Oversight: abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroner, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of HIPAA.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization of Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your provider or the provider's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

I consent to be contacted by regular mail, by e-mail or by telephone (including a cell phone number) regarding any matter related to my account by the clinic or any entity to which the clinic assigns my account. I also consent to the use of any updated or additional contact information that I may provide by the clinic or any entity to which the clinic assigns my account, as well as to the use of technology, including auto-dialing and/or pre-recorded messages in contacting me.

Authorization to Provide Consent for Medical Care to a Minor Child

When you leave your child under the age of 18 in the care of others, it is important to provide for authorization of urgent medical care. By completing and signing the authorization form below, you will enable the appointed adult to give the medical provider permission to provide medical treatment to your child when you are unavailable to authorize required treatment in person.

Child's Name: ____DOB:__________________________

Child's Name: ____DOB:__________________________

Child's Name: ____DOB:__________________________

I/We the undersigned Parent(s) or Legal Guardian(s) of the child listed:

Biological Parent or Legal Guardian (please print):____

Signature of Parent or Legal Guardian: ________________________________ Date: _________________________

Contact Number of Parent or Legal Guardian: ____

Consent to Treat gives permission for the appointed adult (listed below) standing in for the biological parent or legal guardian to consent to such treatments including but not limited to: diagnostic examinations, including radiology and laboratory tests, and necessary medical treatment that need to be performed by order of the Medical Provider.

____

(Name of adult(s) appointed for authorization of medical treatment for the above minor child)

I, the appointed adult agrees to and may consent to the above-named child's medical care and medically necessary procedures when such services are recommended and supervised by a Medical Provider who is licensed in the state of Wyoming where the services are to be provided.

Appointed Adult's Signature:
____Date:__________________________

Address: _______________________________________City: ___________________ State: ______ ZIP: _________

Contact Number: _____________________________ Alternate Number: ____________________________

This consent will remain in effect for one year after signed date, unless it is sooner revoked in writing.