West Valley UrgentCare

Patient Information

Name: _____ Sex ☐ M ☐ F Date of Birth: _____
Last First Middle

Social Security Number: _____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Address: _____
Street (Include Apt #) City State Zip

Home Phone: _____ Cell Phone: _____

E-Mail: _____

Employer: _____ Work Phone: _____

Primary Care Physician: _____
Name City State Phone

Emergency Contact: _____
Name Relationship to Patient Phone

Responsible Party: _____
Name Relationship to Patient Date of Birth

_____
Address Phone

Primary Insurance: _____

Insurance Subscriber: _____ Subscriber Sex: ☐ Male ☐ Female
Name

Subscriber Date of Birth: _____ Subscribers Social Security #: _____

Policy #/Subscriber ID # _____ Subscriber's Employer: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Secondary Insurance: _____

Insurance Subscriber: _____ Subscriber Sex: ☐ Male ☐ Female
Name

Subscriber Date of Birth: _____ Subscribers Social Security #: _____

Policy #/Subscriber ID # _____ Subscriber's Employer: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Consent for Medical Treatment and Release of Benefits and Information

I agree to examination and treatment by West Valley Urgent Care medical personnel, including but not limited to injections, local anesthetics, minor surgical procedures or other procedures discussed with me and recommended by West Valley Urgent Care Providers. I have verified the information on the Patient Information and authorize my insurance benefits to be paid directly to the doctor. I authorize the doctor or the insurance company to release any information required for this claim.

_____ _____ _____
Signature Relationship to Patient Date

WestValley UrgentCare

Language, Ethnicity & Race Data Collection

Patient Name: _____ Date of Birth: _____

Language Information Request

Language the patient currently speaks? _____

Primary (Native) language spoken by the patient? _____

Secondary language spoken by the patient? _____

Ethnicity and Race

___ No, not of Hispanic, Latino/a, or Spanish origin

___ Yes, Mexican, Mexican American, Chicano/a

___ Yes, Puerto Rican

___ Yes, Cuban

___ Yes, Another Hispanic, Latino/a, or Spanish origin

___ Prefer not to disclose

What race(s) that best fits you. (Check all that apply)

___ American Indian or Alaska Native

___ Caucasian

___ Black or African American

___ Chinese

___ Filipino

___ Japanese

___ Asian

___ Other Pacific Islander

___ Indian

___ Native Hawaiian

___ Multiracial

___ Other

Please specify: _____

___ Prefer not to disclose

West Valley Urgent Care L.L.C.

FINANCIAL AGREEMENT

Welcome to West Valley Urgent Care (WVUC). We are committed to providing you with the best possible medical care. The following is a statement of our Financial Policy, which we require you read and sign prior to receiving treatment.

I understand that WVUC participates in a variety of insurance plans and that in order to ensure appropriate insurance billing it is my responsibility to:

- Provide my insurance card at each visit.
- Be prepared to pay my co-payment responsibility at each visit, which is collected prior to being treated, unless prior arrangements have been made with the WVUC Billing Department.
- To pay for medical services **not covered** under your insurance plan. Payment for these services is due at check out after services have been rendered, or we will bill the patient for the total.

I understand that if the patient is a minor (18 years and younger) that I am financially responsible for services provided and that I must provide the insurance card, any referrals and/or payment.

I understand that WVUC will provide assistance with some insurance questions; however, I must contact my insurance company with questions regarding specific coverage issues.

I understand that if I do not have insurance, that the initial office visit payment is due prior to services being rendered. I understand that any additional services provided/prescribed by WVUC, such as x-rays, injections and etc. are extra. I further understand I will be provided with the amount due prior to any additional services being rendered and that payment for the additional services is due at check out.

I understand that if WVUC is unable to verify my eligibility with my insurance company, I may be required to make a monetary deposit and that upon receipt of payment from my insurance company; I will be reimbursed minus any co-payments, co-insurances and/or deductibles, if any.

I understand that if at 30 days, of WVUC's bill submission date to my insurance carrier has not responded, my account balance will be transferred to patient responsibility and a billing statement will be sent to me and I will contact my insurance carrier to request prompt release of payment for the services received.

In the event that I fail to pay the outstanding balance of my account to WVUC for services provided to me, I understand that my account will be turned over to a collection agency and I will be responsible for an additional 35% collection fee, as well as attorney fees and interest charges.

Acknowledgement of Understanding

I acknowledge that I have read and fully understand the Patient Financial Agreement as outlined above. I have also been given a copy of the Patient Financial Agreement for reference.

Patient/Responsible Party Signature	Printed Name	Date

17218 N. 72nd Drive, Suite 100 ▪ Glendale, Arizona 85308
14811 W. Bell Road, Suite 100 ▪ Surprise, Arizona 85374
4110 N. 108th Ave. Suite 101 ▪ Phoenix, Arizona 85037

Phone (623) 334-8670 ▪ Fax (623) 334-8675
Phone (623) 815-9073 ▪ Fax (623) 815-9201
Phone (623) 218-0780 ▪ Fax (623) 218-0786

Revised 02/10/2012

West Valley Urgent Care L.L.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*** You May Refuse to Sign This Acknowledgement ***

I, _____, have received a copy of this office's
(Patient's Name)

Notice of Privacy Practices.

_____

Please Print Name (Responsible Party)

_____

Signature (Responsible Party)

_____

Date

_____

For Office Use Only

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

_____

_____

_____

Arrowhead - 17218 N. 72nd Dr. Ste 100 – Glendale, AZ 85308 Phone: 623-334-8670 Fax: 623-334-8675
Surprise - 14811 W. Bell Rd. Ste 101 – Surprise, AZ 85374 Phone: 623-815-9073 Fax: 623-815-9201
Avondale - 4110 N. 108th Ave Ste 101 – Phoenix, AZ 85037 Phone: 623-218-0780 Fax: 623-218-0786

WestValley UrgentCare

HEALTH HISTORY

Patient Name: _____ D.O.B. _____

Reason for today's visit? _____

Date Illness/Injury began? _____

Medication Allergies & Reaction: _____

_____

Other Allergies & Reaction: _____

Please make an (x) by any of these conditions you may have or have had in the past:

____ Heart disease
____ High blood pressure
____ High cholesterol
____ Lung disease
____ Asthma
____ Tuberculosis/TB
____ Sleep Apnea
____ Stomach disease
____ Bowel disease
____ Liver disease
____ Kidney, bladder or prostate disease
____ Chronic skin disease
Joint replacement
____ Spine disorder
____ Muscle disease
____ Stroke
____ Seizures
____ Severe headaches
____ Nerve impairment
____ Anemia or other blood disorder
____ Depression
____ Mental health problems
____ Diabetes
____ Hypoglycemia
____ Thyroid disease
____ Cancer (past or present)
____ Blood clots
____ Bleeding tendency
Other: _____
_____

Current Medications – Name, Dose, & Frequency (Include non-prescription products)

1.) _____ 2.) _____

3.) _____ 4.) _____

5.) _____ 6.) _____

Personal Habits

Do you drink caffeinated beverages (coffee, tea, soda)? _____ cups per day? _____
Do you drink alcoholic beverages? _____ If yes, _____ drinks per ____ day ____ week ____ month
Do you smoke or chew tobacco? _____ If yes, _____ per day, _____ years of use
If no, any prior tobacco use? _____ years

Major Surgeries or Illness

Approximate Date: _____ Type: _____

Approximate Date: _____ Type: _____

Approximate Date: _____ Type: _____

Special Considerations

□ Legally Blind □ Hearing impaired □ Need handicap facilities □ Pregnant □ Attempting Pregnancy

□ Alcohol abuse (describe): _____ □ Substance abuse (describe): _____

□ None of the above

West Valley Urgent Care L.L.C.

I, _____ D.O.B. _____
(Patient's Name)

Hereby authorize West Valley Internal Medicine, L.L.C. to discuss my personal medical records with:

_____
(Name of Person(s) [EXCLUDING MEDICAL PROFESSIONALS])

_____
(Relationship to Patient)

☐ I wish to release ALL aspects of my records to the above mentioned person(s).
☐ I wish to release Limited aspects of my records to the above mentioned person(s).

Please limit the information to:

Lab Reports _____ Referral Information _____
Imaging Results _____ Office Visit Notes _____
Prescriptions _____ Misc. Documents _____

☐ At this time I DO NOT wish to authorize West Valley Internal Medicine, L.L.C. to discuss my records with anyone other than myself.

I understand that I may revoke or change this release at any time at my discretion.

Formal advance directives are documents written in advance of serious illness that state your choices for health care, or name someone to make those choices, if you become unable to make decisions. Through advance directives, such as living wills and durable powers of attorney for health care, you can make legally valid decisions about your future medical treatment.

☐ I already have an advanced directives on file with the state of AZ and will bring in a copy for your files.
☐ I do not currently have an advanced directives on file and would like more information on how to put on into place.
☐ I do not currently have an advanced directives on file but would not like to complete one at this time.

X _____ _____ / _____ / _____
Patient's Signature / Legal Guardian Date

X _____ _____ / _____ / _____
Office Staff Signature Date

17218 N. 72nd Drive, Suite 100 • Glendale, AZ 85308 Phone: 623-334-8670 • Fax: 623-334-8675
14811 W. Bell Road, Suite 101 • Surprise, AZ 85374 Phone: 623-815-9073 • Fax: 623-815-9201
4110 N. 108th Ave., Suite 101 • Phoenix, AZ 85037 Phone: 623-218-0780 • Fax: 623-218-0786