



**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



## 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

\_\_\_ Other Pacific Islander

\_\_\_ Caucasian

\_\_\_ Indian

\_\_\_ Black or African American

\_\_\_ Native Hawaiian

\_\_\_ Chinese

\_\_\_ Multiracial

\_\_\_ Filipino

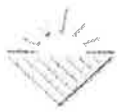
\_\_\_ Other

\_\_\_ Japanese

Please specify: \_\_\_\_\_

\_\_\_ Asian

\_\_\_ 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.

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### 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.

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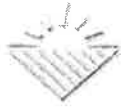
Patient/Responsible Party Signature

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Printed Name

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Date



# 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)



# 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:

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

### 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, \_\_\_\_\_  
(Patient's Name)

D.O.B. \_\_\_\_\_

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