# PATIENT INFORMATION

| | | | |
|---|---|---|---|
| Last Name: | | Middle Name: | |
| First Name: | | DOB: | Sex: Male/Female |
| SS# | Marital Status: Married Single Divorced Widowed | | |

**HOME ADDRESS**

| | | | |
|---|---|---|---|
| Address (include apt. #): | | City: | State: Zip: |
| Home Phone: | Cell: | Other: | |
| Email: | | | |

**EMPLOYER**

| | |
|---|---|
| Employer Name: | Work Phone: |

**PRIMARY CARE PHYSICIAN**

| | | | |
|---|---|---|---|
| Physician Name: | City: | State: | Phone: |

**RESPONSIBLE PARTY**

| | |
|---|---|
| Name: | Phone |
| Relationship to patient: | |

**EMERGENCY CONTACT**

| | |
|---|---|
| Name: | Phone |
| Address: | Relationship to Patient: |

**NO INSURANCE/ SELF PAY**

☐ Cash ☐ Credit/Debit

**INSURANCE INFORAMTION**

| | | |
|---|---|---|
| Primary Insurance: | | Insurance subscriber: |
| Subscriber DOB: | Sex: | Subscriber SS# |
| Subscriber's employer: | | |
| Policy#/Subscriber ID# | | Relationship to patient: |
| Secondary Insurance: | | Insurance subscriber: |
| Subscriber DOB: | Sex: | Subscriber SS# |
| Subscriber's employer: | | |
| Policy#/Subscriber ID# | | Relationship to patient: |

**LANGUAGE**

| | |
|---|---|
| Primary Language: | Secondary Language: |

**ETHNICITY**

| | |
|---|---|
| ____ Not Hispanic, Latino/a, or Spanish origin | ____Cuban |
| ____ Mexican, Mexican American, Chicano/a | ____ Another Hispanic, Latino/a or Spanish |
| ____ Puerto Rican | ____ Prefer not to disclose |

**RACE**

| | | |
|---|---|---|
| ____Asian | ____ Japanese | ____ Multiracial |
| ____Filipino | ____ Pacific Islander | ____Black/African American |
| ____Chinese | ____ Indian | ____ American Indian |
| | ____Native Hawaiian | ____ Caucasion (White) |
| ____ Other: Specify_____ | | ____ Prefer not to disclose |

**FINANCIAL AGREEMENT**

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

*Provide my insurance card at each visit.
*Be prepared to pay my co-pay or deductible responsibility at each visit, prior to being treated.
*If the patient is a minor (under 18 years of age) I am financially responsible for services provided
*It is my responsibility to contact my insurance company with questions regarding specific coverage issues
*If I do not have insurance, the initial office visit payment is due prior to services rendered.
*Payment for any additional services provided/prescribed by WVUC is due at check out.
*If my insurance eligibility can not be varified by WVUC, I may be required to make a monetary deposit and upon receipt of payment from my insurance company I will be reimbursed minus any co-pays, co-insurance and/or deductibles if any.
*If insurance denies payment for any procedure, I agree to be financially responsible for payment.
*After 30 days of WVUC bill submission date to my insurance company has not responded, my account balance will be transferred to patient responsibility.
*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.

**ACKNOWLEDGEMENT OF UNDERSTANDING**

***I acknowledge that I have read and fully understand the Patient Financial Agreement as outlined above***

Patient Name:_____
Patient Signature: Date:

**CONSENT FOR MEDICAL TREATMENT**

***I agree to examination and treatment by West Valley Urgent Care personnel, including but not limited to injections, local anestheticsminor surgical procedures or other procedures discussed with me and recommended by West Valley Urgent Care***

Signature:_____ Date:_____

**PERMISSION TO CONTACT**

***I understand that West Valley Care uses multiple methods to contact their patients with any information pertaining to their health care such as test results, referral status, and appointment stauts. Methods used to inform patient's are emil, text, phone calls, and online patient portal.***

_____ I have read the above and give WVC permission to contact me using these methods
_____ I DO NOT give WVC permission to contact me by way of unsecure communication

Signature of patient/parent:_____ Date:_____

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

***I have received a copy of this office's notice of Privacy Practices***

Patient Name(responsible party):_____
Patient 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 ____ Communication barriers
____ Emergency Situation
____ Other (please specify)

| HEALTH HISTORY | | | | | |
|---|---|---|---|---|---|
| Patient Name: | | | | D.O.B. | |
| Reason for visit: | | | | Date Illness began? | |
| Medication and other allergies and reactions: | | | | | |
| **DO YOU HAVE NOW OR WITHIN THE PAST YEAR** | | | | | **Medications and Dose** |
| Heart Disease | Yes/No | Stroke | Yes/No | **Caffeine** Yes/ No | |
| High Blood Pressure | Yes/No | Seizures | Yes/No | # per week | |
| High Cholesterol | Yes/No | Severe Headaches | Yes/No | Type: | |
| Lung Disease | Yes/No | Nerve Imparment | Yes/No | **Alcohol** Yes/No | |
| Asthma | Yes/No | Depression | Yes/No | # per week | |
| Tuberculosis/TB | Yes/No | Diabetes | Yes/No | Type: | |
| Sleep Apnea | Yes/No | Hyperglycemia | Yes/No | **Tobacco** Yes/No | |
| Stomach Disease | Yes/No | Thyroid Disease | Yes/No | per week: | |
| Bowel Disease | Yes/No | Blood Clots | Yes/No | Date Quit: | |
| Liver Disease | Yes/No | Bleeding Tendency | Yes/No | **Major Surjuries or Illness** | |
| Chronic Skin Disease | Yes/No | Mental Health problems | Yes/No | | |
| Joint Replacement | Yes/No | Anemia | Yes/No | | |
| Spine Disorder | Yes/No | Cancer Past/Present | Yes/No | | |
| Muscle Disease | Yes/No | Kidney/bladder/prostate disease | Yes/No | | |

***To the best of my knowledge, the questions on this form have been accurately answered.***
***I understand that providing incorrect information can be dangerous to my/or my child's health.***
***It is my responsibility to inform the doctor's office of any changes in my/my child's medical status***
***I also authorize the health care staff to perform necessary health care services I or my child may need.***

Signature of patient/ parent : Date:

**RELEASE OF MEDICAL INFORMATION AND RECORDS**

***I hereby authorize West Valley Urgent Care, L.L.C. to discuss my medical records with the following individuals:***

Name: Relationship to Patient:

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

____ I DO NOT wish to authorize WVUC to discuss my records with anyone other than myself.

**ADVANCED DIRECTIVES**

***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 power of attorney for health care, you can make legally valid decisions about your future medical treatment***

____ I already have an advance directive on file with the state of AZ and will bring in a copy for your files

____ I do not have an advance directive on file and would like more information on how to put one in place

____ I do not currently have an advance directives on file but would NOT like to complete one at this time.

Patient Signature/Legal Guardian: _____ Date:_____

Office Staff Signature: _____ Date:_____