AFTER HOURS URGENT CARE
Your hometown urgent care!

1550 Eatonton Rd
Madison, GA 30650
706-438-6486
Fax 978-645-6896
www.AfterHoursUrgentCareGA.com

Patient Information

Demographics:

Last Name:_____ First Name:_____ MI:_____

Date of Birth:_____ Sex: ☐ Male ☐ Female

Address:_____
Street *City, State* *Zip*

Home Phone:_____ Work:_____ Mobile:_____
A confidential message may be left on your telephone answering machine or voicemail.

Race: ☐ Asian ☐ Black ☐ Hispanic ☐ White ☐ Other Marital Status: ☐ Married ☐ Single

Social Security #:_____ Employed: ☐ Full-time ☐ Part-time

Employer:_____ Student: ☐ Full-time ☐ Part-time

Employer Address:_____
Street *City, State* *Zip*

Emergency Contact:_____

Relationship:_____ Phone: _____

Responsible Party:

Name:_____ Sex: ☐ Male ☐ Female

Address:_____
Street *City, State* *Zip*

Social Security #:_____ Date of Birth:_____

Home Phone:_____ Work:_____ Cell:_____

Insurance Information:

Primary Insurance: _____ Policy, Member or ID#:_____
Policy Holder Name & Date of Birth:
_____

Secondary Insurance: _____ Policy, Member or ID#:_____
Policy Holder Name & Date of Birth:
_____

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URGENT CARE

Insurance Plans and Policies

- We are currently working with most insurance carriers and have pending agreements. It is your responsibility to check with your insurance plan prior to your visit to make sure we are in network and a participating provider.
- Knowing your insurance benefits is **your** responsibility. As a courtesy, After Hours Urgent Care, LLC will verify your insurance, but this does not guarantee benefits.
- If a patient is not covered by an out of network plan, we offer a competitive self-pay rate for all services.

Proof of Insurance

- A copy of a valid insurance card will be needed on the day of your appointment.
- If you do not have a copy of your card on the day of treatment, you will be considered a self-pay patient.

Co-payments and Billing Statements

- Co-payments are due before services are rendered.
- All co-payments and deductibles are based upon primary insurance coverage.
- We will file your charges with your insurance company. You will be responsible for any remaining balance.
- Failure to receive your statement does not relieve you from your financial obligations. It is your responsibility to notify our office with any address or contact changes.

Cash, Check, or Credit Cards

- Returned checks are subject to a $25.00 fee.
- Visa, Mastercard, Discover, and AMEX are accepted.

Patient Name:_____

☐ I authorize my health plan to pay benefits directly to After Hours Urgent Care, LLC. I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including, but not limited to payment of those fees and charges not directly reimbursed to After Hours Urgent Care, LLC by any insurance policy, self-insurance program or other benefit plan. I further agree to accept full financial responsibility for payment of charges rendered to_____.

Name of minor or dependent adult if appropriate

This authorization shall remain in effect until revoked by me in writing except to the extent that action has been taken in reliance on treatment payment and health care operations. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization. I have read and fully understand the above consent for treatment, release of medical information, financial responsibility and insurance authorization.

Patient or Guardian Signature:_____ Date:_____

Print Name:_____

AFTER HOURS
URGENT CARE

HIPAA Patient Consent Form

Patient Name:_____

HIPAA Patient Consent Form This consent form goes over the Health Insurance Portability & Accountability Act of 1996. HIPAA provides information about how we may use and disclose protected health information about you. This Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may be subject to change at any given point. If we change our Notice, you may obtain a revised copy by contacting our office, or going to our Website at afterhoursurgentcarega.com.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, health care operations, and/or coordination of care.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, health care operations, and coordination of care. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment, health care operations, and/or coordination of care.
- The patient has the right to obtain and view the Notice of Privacy Practices containing a more complete description.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to look over and/or obtain a copy of their health care records with a signed release.
- The patient has the right to restrict the uses of their information.
- The patient may provide a written request to revoke this consent at any time during care.
- If the patient refuses to sign the consent form for purposes of treatment, payment, health care operations, and/or coordination of care, the Practice has the right to refuse care to the patient.

Patient or Guardian Signature:_____ Date:_____

Print Name:_____

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Patients Name: _____ **DOB**: _____

*If you should need anyone other than yourself to pick up prescriptions, paperwork, or If we should need to contact you regarding appointments, clinical results, prescriptions, billing information, or any other matters not covered herein, and you are not available to take the call or if individual listed below is requesting any matters listed above, is there someone you authorize us to give this information to?

Yes___ (if Yes, please list these person(s) names below No ___

1. Name of Authorized Individual_____ Relationship_____

   Phone Number_____ Information to be given: _____

2. Name of Authorized Individual_____ Relationship_____

   Phone Number_____ Information to be given: _____

*What phone number do you prefer for us to contact you by? (Please Check One)

Home ____ Cell ____ Preferred Phone # _____

Email: _____ Cellphone number: _____

I have verified the information above and know it to be and correct.

_____ _____ _____ _____

Patient / Parent or Guardian (Please Print) ***Patient / Parent or Guardian Signature*** ***Relationship*** ***Date***

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URGENT CARE

Visit Reason:

☐ Illness ☐ Injury ☐ School/Sports Physical ☐ Drug Screen

Condition is related to: ☐ Work ☐ Auto ☐ Home ☐ Sports ☐ Other ☐ None

Today's Problem/Injury:_____

Date of Injury/Condition:_____

Primary Care Physician:_____ PCP Phone #_____

Pharmacy & Location:_____

Patient Name:_____

Consent for Treatment:

☐ I hereby consent to medical evaluations, testing, X-Rays, and/or treatment provided by the staff of After Hours Urgent Care, LLC. I understand the benefits, risk, and possible side effects of receiving medications and vaccines and that it is my responsibility to provide any information relevant to health history, possible medication interactions and allergies.

☐ I understand that if the provider has ordered additional laboratory test that the collected specimens may be sent to a local laboratory for testing. After Hours Urgent Care, LLC will forward my payer information to the laboratory, but I will be responsible for the charges incurred for these services and will receive a separate bill from the laboratory. I understand that there may be a portion of the cost of Durable Medical Equipment that is not covered by my insurance company and I will be responsible for the balance.

☐ I understand that After Hours Urgent Care, LLC may request and use my prescription medication history from other healthcare providers, third party pharmacy, or state drug registry for treatment purposes.

☐ I understand that After Hours Urgent Care, LLC utilizes Nurse Practitioners and/or Physician Assistants.

☐ I consent to allow After Hours Urgent Care, LLC to carry out my treatment, obtain payment and to carry out health care operations. My protected health information may be disclosed to my health plan and/or its agents as necessary to verify benefits, authorize services, and process medical claims. My protected health information may be disclosed to outside health agencies or institutions involved in my continuing care when I am transferred to another facility and/or for emergency care purposes. I allow the fax transmittal of my medical records if necessary. My physician(s) may also share my information with referring physicians for continuing care. My protected health information may include medical information or any information pertaining to the examination, treatment, history, which may include psychiatric, HIV/AIDS, sickle cell, alcohol and or drug information and medical information, changes to my health plan and/or their acting intermediaries and/or agents.

Patient or Guardian Signature:_____ Date:_____

Print Name:_____

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Medical History

Patient Name: _____

Current Medications:

Include medication name and dosage for all prescription and non-prescription medications that you are currently taking.

_____

_____

_____

_____

Allergies: _____

Have you ever been diagnosed with any of the following conditions: (Please check all that apply)

_____ Cancer	_____ Circulation Problems	_____ Fibromyalgia
_____ Chest Pain	_____ Diabetes	_____ Infectious Disease
_____ Heart Disease	_____ Thyroid Disease	_____ Hepatitis
_____ High Blood Pressure	_____ Seizure Disorder or Epilepsy	_____ Frequent Headaches
_____ Heart Attack	_____ Asthma	_____ Hearing Difficulties
_____ Pace Maker	_____ Emphysema	_____ Vision Difficulties
_____ Stroke or TIA	_____ Bronchitis	_____ Numbness of Tingling
_____ Congestive Heart Failure	_____ Chemical Dependency	_____ Dizziness
_____ Blood Clots	_____ Rheumatoid Arthritis	_____ Weakness
_____ HIV/AIDS	_____ Mental Health Issues	

_____ Surgery Type: _____ Date: _____

Are you pregnant? ☐ Yes ☐ No If yes, due date: _____

Do you use tobacco products? ☐ Yes ☐ No If yes, how many times per day: _____

What type:_____

Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how much per day: _____

Do you have any family history of any the above conditions? ☐ Yes ☐ No If yes, please list condition and relationship. _____

_____