Inland Urgent Care

"Keeping the Valley at Work"

PATIENT INFORMATION/RELEASE OF RECORDS/INSURANCE WAIVER

Menifee	Temecula	Wildomar	Canyon Hills	Corona
P: (951) 246-3033	P: (951) 303-6440	P: (951) 600-0110	P: (951) 244-2224	P: (951) 279-4994
F: (951) 246-7373	F: (951) 303-6449	F: (951) 600-1489	F: (951) 244-1244	F: (951) 279-4993

Reason For Visit: _____

Patient Name: First: _____ **Middle:** _____ **Last:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____ **E-Mail:** _____

Date of Birth: _____ **Sex:** _____ **Patient Social Security #:** _____

Marital Status: _____ **Cell Phone:** _____ **Home Phone:** _____

If Patient is a Child: Parent or Legal Guardian Name: _____ **Relation:** _____

Emergency Contact: _____ **Relation:** _____ **Phone:** _____

Primary Doctor: _____ **Phone #:** _____

Would you like for today's office visit/labs/x-rays/etc. be faxed to your primary? Yes _____ **No** _____

Can we leave a voicemail regarding negative lab/x-ray results: Yes _____ **No** _____

Primary Insurance: _____ **Policy ID:** _____ **Group #:** _____

Policy Holder Name: _____ **Relationship:** _____

Date of Birth: _____ **Social Security #:** _____

Secondary Insurance: _____ **Policy ID:** _____ **Group #:** _____

Policy Holder Name: _____ **Relationship:** _____

Date of Birth: _____ **Social Security #:** _____

Race: Asian Hispanic White Black/African American

Preferred Language: English Spanish Sign Language Other: _____

Ethnicity: Latino Not Latino White Hispanic Black/African American Native American American Indian Asian/Pacific Islander Other: _____

CONSENT TO USE & DISCLOSE HEALTH INFORMATION FOR TREATMENT & PAYMENT, OR HEALTHCARE OPERATION

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatments and any plans for the future care or treatment. I understand that this information serves: A basis for planning my care and treatment. A means of communication among the many healthcare professionals who contribute to my care. A source of information for applying my diagnosis and surgical information to my bill. A means by which a third party payer verifies that services billed were actually provided. This may include routine healthcare operations such as assessing quality care and reviewing the competence of the healthcare professionals.

I understand that I have the right to receive a copy of the **Notice of Information Practice** that provides a more complete description of the information uses and discloses prior to signing this consent. I understand that the organization reserves the right to change their notice and practice site(s). I understand that I have the right to object the use of my health information for disclosure purposes. I understand that I have to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restriction(s) requested.

INSURANCE VERIFICATION WAIVER

I hereby state that I have provided Inland Urgent Care my insurance card that reflects my current medical plan and policy presented along with proper photo identification to bill accordingly and they will collect from responsible party any and all deductibles and co-insurance. However, should this insurance coverage be ineffective or no longer valid, I will be financially responsible for any balance owed to Inland Urgent Care. By signing this agreement, I acknowledge that I am fully aware that a co-pay will be required for any visits.

HIPAA NOTICE OF PATIENT PRIVACY PRACTICE: I have received and read this document. Would you like a copy: **Yes No**

By signing below, I consent to the examination and treatment by a licensed provider on staff at Inland Urgent Care.

Print Name: _____ Date: _____

Signature of Patient or Legal Represenative: _____

Relationship: _____ Date: _____

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FINANCIAL POLICY

PLEASE READ THOROUGHLY AND SIGN, BY SIGNING YOU AGREE TO THE FOLLOWING:

1. As a courtesy, we will process a claim to your insurance as long as we can establish coverage at the time of your visit. We will do our due diligence to ensure coverage by your insurance Understandably, if your insurance is invalid, expired and/or out of network, by signing, you acknowledge you will be financially responsible for any balance deemed patient's responsibility or non-covered service. **It is patients responsibility to understand the terms of their insurance plan.**

2. You must present your insurance card, photo I.D and any authorizations you may have, prior to being seen. Without these items, we are unable to verify coverage and will be unable to see you.

3. If your insurance denies payment, on your behalf, you will be asked to pay the outstanding balance. We accept cash, check and credit. If you do not pay in a timely manner, you will be responsible for any and all charges in accordance with the laws. Should your account become delinquent and over 90 days old, you agree to reimburse us the fees of any collection agency, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

4. In accordance with American Medical Association CPT guidelines, we reserve the right to charge for telephone calls you may have with our medical professionals that include evaluation and management of your medical condition. We will bill your insurance for such calls, but if it is not covered by your insurance you may be financially responsible for such charges.

5. Self-Pay Patients (including patients with no insurance and patients with insurance plans that we do not participate in): Payment for medical services is required prior to services being rendered.

6. Should you need to cancel or change your office appointment, we ask that you contact us **24 hours prior to your appointment time**. Should you fail to meet the 24 hour timeframe, you agree to pay a $50.00 no show fee for an office visit.

7. By signing, you also agree that you and/or your employer pay the monthly insurance premiums, your insurance company is accountable to you. Do not hesitate to contact your insurance directly if you disagree with your payment or to find out the status of your claims.

If you have any questions regarding this financial policy, please ask or call BEFORE you are seen by our provider.

_____ _____

Patient or Guardian - Signature Date

_____

Patient or Guardian - Printed

11-1-19