QUALITY URGENT CARE & WELLNESS

Payment_____ Room_____

Patient Name (FirstLast)_____

SSN _____Date of Birth: _____ Sex: □ M □ F

Phone Number_____Email:_____

Address:_____ Apt#:_____City:_____

State:_____Zipcode:_____ Preferred Language: _____ Do you need an interpreter □Y □N

Primary Care Physician:_____ PCP Phone#:_____

Emergency Contact (First, Last): _____

Relationship:_____Home Phone Number: _____Cell Phone:_____

Responsible Party/Guarantor for Minor Patient's Name: _____

Date of Birth: _____Sex: □ M □ F SSN: _____

Relationship to Patient: _____ Contact Number _____

Address: _____Apt#: City:_____State:__Zipcode:_____

REASON FOR VISIT

Urgent Care Visit Insurance or Self Pay	**Physical** Self Pay	**Employer Evaluations** Paid By Employer
___ **Illness** (Sick Visit) __ **Injury - Work Related** ____Yes ____No	___ **DOT** ___ **School** ___ **Sport** ___ **Employment** ___ **Other**	__**Breath Alcohol Test** __**Drug Screen (Rapid)** __**Workers Comp Visit** __**Other**

Consent for Treatment: I understand that there are inherent risks and dangers associated with treatment through an Urgent Care Setting and assume responsibility for being seen or having my dependent/child seen and treated by QUCW staff members. I hereby waive, rel ease, and discharge all claims of damage, personal injury, or personal illness against QUCW because of being seen in this setting. This release is intended to indemnify and hold harmless QUCW and its staff members from all liability related to potential hazardous community exposure. I understand that QUCW treats conditions like Covid-19, Influenza, Streptococcus, Scabies, and Head Lice, and although risk for exposure is low, there still is a risk presenting when being treated in an urgent care setting. I consent to medical treatment for myself or minor child. I understand that an examination and treatment I receive is not intended to replace a primary care assessment, but instead to supplement in times of acute need. I understand that QUCW is not a primary care physician. I also understand that I should include in this intake form my medical history including but not limited to current medications and current medical conditions. I finally understand that QUCW may not be able to see me if I present with the same issue 3 times consecutively in a 6-month period or 4 times per year for the same issue. I agree to the Notice of Privacy Practices that can be provided per my request. I agree to have information, results, or excuses sent to a non-secure email that I have written above at my request. **Consent for Payment:** recognize that by signing this agreement, it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid. It is also my responsibility to present every visit with my ID and, if applicable, my most up to date insurance card information to avoid additional costs by previous and current insurance companies. If I am without insurance and self-paying, I understand that I must pay the 175.00 fee to initially be seen. I am also responsible for paying for any procedures, medications or supplies discussed with th e provider upon discharge. I recognize and accept responsibility for services rendered regardless of insurance coverage. I unde rstand that payment is due before service. I also understand that my insurance may not cover my entire visit and will require payment before my next assessment. I recognize that QUCW does not provide refills for controlled substances and can only provide a 1-time prescription refill for medications I am currently taking or recently have run out of. I am aware that QUCW may not be able to fill all my prescriptions if I present for refills and I will need to present with prescription bottles or pharmacy print out for review. **Consent for Procedures/Xray/Send out Labs:** I recognize that by signing below I give clinical consent for myself or my minor to have an Xray, Laboratory Testing, or Pelvic Examination. If having an X-ray procedure, I report no risk of pregnancy. If send out laboratory testing is required through my contracted insurance lab (Quest or LabCorp) and assume responsibility of any costs for send out testing. Finally, I understand that if my condition requires evaluation of the groin/privates that I give consent for assessment and evaluation. **Consent for Release of Information** I authorize Quality Urgent Care & Wellness, to disclose my medical information & other protected health information to the following persons, physician, or hospital. **If no one is listed, no information will be released**

Name (Family or Doctor)	Relationship to patient	Code to access records

Patient Signature/Guardian Signature: _____Date:_____

QUALITY URGENT CARE & WELLNESS

Patient Name: _____ ROOM _____

Do you need a work note? ☐ Yes ☐ No

Symptoms:

Pharmacy: ☐ CVS ☐ Publix ☐ Walgreens ☐ Walmart ☐ DOD ☐ Other _____

Zip Code or Street of pharmacy_____

Allergies: ☐ Penicillin's ☐ Sulfa ☐ Ace Inhibitors ☐ NSAID's ☐ Other _____

☐ No Drug Allergies

Medications: Name/Dosage		
☐ List Provided		
☐ None		

Past Medical History: ☐ Heart Disease ☐ High Blood Pressure ☐ Diabetes ☐ COPD ☐ Asthma

☐ Other _____

Past Surgical History: ☐ Gallbladder ☐ Appendix ☐ Heart ☐ Lung ☐ Hysterectomy

☐ Tonsils/Adenoids

☐ Other _____

Social History:

☐ Tobacco ☐ Alcohol ☐ Drug Use ☐ Recent travel/Exposure

Family History: ☐ Heart Disease ☐ Diabetes ☐ Asthma ☐ Cancer

☐ Other _____

Preventative:

Last Tetanus:_____

Vital Signs: (staff only)

Temp		**Pulse**		**Resp**		**B/P**	
O2		**Ht**		**Wt**		**Pain**	

Breastfeeding ☐ **Yes** ☐ **No**	**Pregnant** ☐ **Yes** ☐ **No**	**LMP:**