PATIENT INFORMATION

LAST NAME | FIRST | MI | ( ) PHONE

STREET / MAILING ADDRESS | CITY/STATE/ZIP

DATE OF BIRTH | AGE | SEX | MARITAL STATUS | SOCIAL SECURITY NO. | REGULAR PHYSICIAN

MEDICATION ALLERGIES OR SPECIFIC MEDICAL CONDITIONS WE SHOULD BE AWARE OF

EMPLOYER | ( ) PHONE | OCCUPATION

RESPONSIBLE PARTY:

LAST NAME | FIRST | M I | SOCIAL SECURITY NO. | DATE OF BIRTH

STREET ADDRESS | CITY/STATE/ZIP | ( ) HOME PHONE

EMPLOYER | ( ) PHONE | OCCUPATION

DO YOU HAVE HEALTH INSURANCE?_____YES_____NO. PLEASE PROVIDE US WITH YOUR INSURANCE CARD SO THAT WE MAY COPY IT FOR OUR RECORDS.

PREFERRED LANGUAGE: _____

RACE:
- ☐ AMERICAN INDIAN OR ALASKA NATIVE
- ☐ ASIAN
- ☐ BLACK OR AFRICAN AMERICAN
- ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
- ☐ WHITE

ETHNICITY:
- ☐ HISPANIC OR LATINO
- ☐ NOT HISPANIC OR LATINO

EMERGENCY CONTACT | ( ) PHONE | RELATIONSHIP

We ask for payment at the time of service unless other plans are pre-arranged.
We are required to collect your insurance plan's co-payment at the time of service.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.
I authorize the release of any medical information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance and other agency reimbursements to Physican Immediate Care. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

GENERAL INFORMATION ON PAYMENT AND PROCEDURE

1. If after sixty (60) days insurance has not responded to the claim, the billing is expected to be paid in full by the responsible party. We do require a payment within 30 days of time of service.

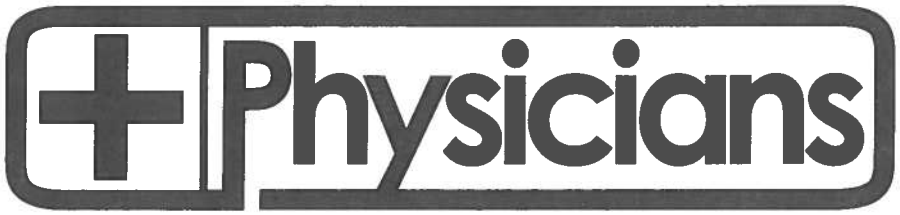
2. Patients with health insurance should remember that services are rendered and charged to the patient. Any dispute over an insurance claim is a matter between the patient and insurance carrier. Should a dispute arise, we will make every effort to help resolve the claim.

AUTHORIZATION AND AGREEMENTS FOR TREATMENT

1. CONSENT TO TREATMENT: I understand that medical treatment will be performed by independent physicians, their assistants, and employees of Physicians Immediate Care Center between the hours of 8:00 a.m. and 7:00 p.m. Physicians Immediate Care Center is not responsible for care between the hours of 7:00 p.m. and 8:00 a.m. I hereby give my authorization and consent to treatment and procedures, and certify that no guarantee or assurance has been made as to the results of such treatment or procedures.
2. RELEASE OF MEDICAL INFORMATION: I hereby authorize **Physicians Immediate Care Center** to release any medical information in connection with these services for health insurance purposes or to the patient's treating physician or physicians.

I HAVE READ AND UNDERSTAND THE ABOVE ACKNOWLEDGMENTS AND AGREEMENTS.

SIGNATURE _____ DATE _____



Immediate Care Center

260 Falls Ave. • Twin Falls, Idaho
208.736.7422

ACKNOWLEDGMENT RECEIPT: HIPAA NOTICE OF PRIVACY PRACTICES

In signing this form, you agree that you have received our **Notice of Privacy Practices.** this Notice, among other points, explains how we plan to use and disclose your protected health information for the purposes of treatment, payment and health care operations.

You have the right to review our **Notice of Privacy Practices** prior to signing this form. It provides more detail on how we may use and disclose your information. The Notice of Privacy Practices may change.

By signing this form, you acknowledge you have received our Notice of Privacy Practices and that HSL and all affiliated covered entities can use and disclose your protected health information an accordance with HIPAA.

Signature of individual or surrogate decision maker

FULL NAME	**SIGNATURE**	**DATE**

Name:_____ DOB:_____ Date:_____

Special Considerations

☐ Legally blind ☐ Need handicap facilities
☐ Hearing impaired
☐ Pregnant
☐ Attempting Pregnancy ☐ None of the above

Patient History

Please Make an (x) by any of these conditions you may have or had in the past:

☐ Heart disease
☐ High blood pressure
☐ High cholesterol
☐ Lung disease
☐ Diabetes (type 1 or 2)
☐ Hypoglycemia
☐ Thyroid disease
☐ Stomach disease
☐ Kidney, bladder or prostate disease
☐ Joint replacement
☐ Liver disease
☐ Bowel Disease
☐ Cancer (past or present)
☐ Anemia or other blood disease
☐ Blood Clots
☐ Bleeding tendency
☐ Stroke
☐ Seizures
☐ Nerve impairment
☐ Cervical spine disorder
☐ Lumbar spine disorder
☐ Severe headaches
☐ Tuberculosis/TB
☐ Muscle disease
☐ Mental health problems
☐ Depression
☐ Chronic skin Disease
☐ Sleep apnea
☐ Other _____ _____

Past medical conditions

_____

Current medications (Include non-prescription products) include strength and dosage

1._____ 3._____ 5._____ 7._____
2._____ 4._____ 6._____ 8._____

Social History

Do you smoke, chew tobacco or E-Vape?..... ☐ Yes ☐ No If yes, which one ☐ S ☐ C ☐ E, ____ per day, ____ years of use.
If no, any prior nicotine use? ____ years of use.

Do you drink alcoholic beverages?..... ☐ Yes ☐ No If yes, ____ drinks per ☐ day ☐ week ☐ month ☐ Abuse

Do or have you used any illegal substances?..... ☐ Yes ☐ No If yes, describe: _____

Do you drink caffeinated beverages (coffee, tea, soda).. ☐ Yes ☐ No If yes, daily intake? _____

Family History (Any Cancer, Blood pressure, Cholesterol, Diabetes, etc...)

☐ Mother:_____ ☐ Deceased
if yes, from what_____

☐ Father:_____ ☐ Deceased
If yes, from what _____

☐ Other:_____

Orthopedic or other major surgeries

_____ / _____
Approx. date Surgery Approx. date Surgery

_____ / _____
Approx. date Surgery Approx. date Surgery

PEDS:

Name:_____ **DOB:**_____ **Date:**_____

Special Considerations

☐ Legally blind ☐ Need handicap facilities
☐ Hearing impaired
☐ Pregnant
☐ Attempting Pregnancy ☐ None of the above

Pediatric Patient History

School/ Daycare:	**Level:**_____ **School/ Daycare name:**_____ ☐ **involved in extracurricular activities**
Living Circumstances:	**Patient Lives with:**_____ **Number of siblings:**_____ **Sleeping arrangements:**_____ **Number of pets:**
Potential Exposure to Toxins:	☐ Second Hand Smoke ☐ Paint Fumes ☐ Fertilizer ☐ Misc. Chemicals ☐ Lead

Past medical conditions

_____

Current medications (Include non-prescription products) include strength and dosage

1._____ 3. _____ 5. _____ 7._____

2._____ 4. _____ 6. _____ 8._____

Social History

☐ Tobacco, E-vape use ☐ Alcohol use ☐ Drug use ☐ Caffeine use

Family History (Diabetes, Cancer, high blood pressure ...)

☐ Mother_____ ☐ Father_____ ☐ Other_____

Orthopedic or other major surgeries

Approx. date Surgery	Approx. date Surgery
Approx. date Surgery	Approx. date Surgery