Immediate Care Center

243 Cheney Drive West • Twin Falls, ID 83301

Phone: (208) 736-7422 Fax: (208)736-8905

→ _____

Name (Last, First, Middle)

_____ M/F _____

DOB Age Sex

_____

Social Security No. Marital Status

_____

Mailing Address

_____

City State Zip

(____)_____(____)_____

Best Contact Number (Optional) Other Number

_____

Confidential E-mail (for patient portal)

_____

Regular Physician

_____

Employer Occupation

(____)_____

Phone Number

Preferred Language: _____

Race: ☐ American Indian or Alaska Native ☐ Asian

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

☐ Black or African American ☐ Decline

☐ White

☐ Decline Pharmacy: _____

Emergency Contact:

Name: _____Phone: (_____) _____**Relationship:**_____

Do you have Health Insurance? ____Yes ____No. If yes, please provide us with your cards for our records.

☐ I Accept ☐ I Decline

To receive text messages from PICC. Number: if different from above. (____)_____

Responsible Party if a Minor:

_____ Relationship: _____

Name (Last, First, Middle) DOB SS#

_____

Mailing Address City/State/Zip

_____(____)_____

Employer Occupation Phone Number

We ask for payment at time of service unless other plans are pre-arranged.

We are required to collect your insurance plan's co-payment at 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 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 PICC. This assignment will remain in effect until revoked be 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 Agreement for Treatment

1. CONSENT TO TREATMENT: I understand that medical treatment will be performed by independent physicians, their assistants, and employees of PICC between the hours 8:00 a.m. and 7:00 p.m. PICC 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(s).

Acknowledgment Receipt: HIPAA Notice of Privacy Practice

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

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

By signing this form, you acknowledge you have receives 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 / Guardian:

Printed Name: _____

Signature: _____

Date: _____