QuickCare
MEDICAL SERVICES

PATIENT'S FULL LEGAL NAME _____ **Date of Birth** _____
(Please Print)

Mailing
Address _____ **City** _____ **State** _____ **Zip** _____

Phone
Home# _____ **Cell#** _____ **Work#** _____

EMPLOYER: _____ **Marital Status** _____

Social Security # _____ **Age** _____ **Gender** _____ **Preferred Pharmacy** _____

Race:
___ White
___ Black or African American
___ Native American or Alaska Native
___ Asian
___ Native Hawaiian or Other Pacific Islander
___ Other _____

ETHNICITY: _____ HISPANIC _____ NON-HISPANIC

PREFERRED LANGUAGE:
_____ ENGLISH _____ SPANISH
_____ OTHER _____

REASON FOR TODAY'S VISIT _____

DATE OF INJURY/HOW HAPPENED _____

RESPONSIBLE PARTY FOR TODAY'S CHARGES for MINOR PATIENT (UNDER 19 YEARS)

Responsible Party _____ DOB _____ EMPLOYER: _____

Relationship _____ SOCIAL SECURITY # _____
(If different from above)

Address _____ City _____ State _____ Zip _____

Contact Phone Home _____ CELL _____ WORK _____

INSURANCE : PLEASE ATTACH ALL INSURANCE CARD(S) TO CLIPBOARD AND COMPLETE

1)Name of Insurance _____ **Policy #** _____
Policyholder Name _____ **Policyholder Address** _____
Relationship to Patient _____ **DOB** _____ **Social Security #** _____
2)**Name of Insurance** _____ **Policy#** _____
Policyholder Name _____ **Policyholder Address** _____
Relationship to Patient _____ **DOB** _____ **Social Security#** _____

Is today's visit work related? **Employer Paid Services** _____ ***OR*** **Workman's Compensation** _____

Company Name _____ Contact Person _____ Phone # _____

Claim # _____ If Work Comp and employer denies the claim you will be responsible for your bill.

PLEASE ATTACH YOUR PHOTO ID TO CLIPBOARD

BY SIGNING THIS DATA SHEET, YOU ARE AUTHORIZING QUICK CARE MEDICAL SERVICES PROVIDERS TO TREAT YOU OR YOUR MINOR CHILD. You expressly consent and agree that, in order to discuss or service your accounts(s) (the "Accounts") or to collect amounts you may owe, Quick Care Medical Services, and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively, "We") may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contact you by sending text messages, emails, using any e-mail address you provide to us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

PATIENT or RESPONSIBLE PARTY *SIGNATURE* _____ **DATE** _____

RESPONSIBLE PARTY PLEASE *PRINT* YOUR NAME _____

Office Use: Date _____ Time _____ Office Staff _____

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Quick Care Medical Services originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communications among the many health 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 can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have bee provided with a *Notice of Information Practices* that provided a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to request restrictions as to how my health information may be used or disclosed to care out treatment, payment, or health care operations

I understand that Quick Care Medical Services is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization my refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I authorize healthcare and medical services to be disclosed and released to: (Family/Friends, etc.) (Please note this release will be honored until changed/updated by the patient/guardian)

NAME(S):	**RELATIONSHIP:**
_____	_____
_____	_____
_____	_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my PHI to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

_____
Patients Signature or Legal Guardian

_____/_____/_____
Date