PATIENT INFORMATION

Name: Last ______________________________ First ______________________________ MI _______

Social Security # __________________________ Date of Birth: ______________ Gender: ☐Male ☐Female

Address:____

City: ______________________________________ State: _______________ Zip: __________________

Phone #: __________________________________ Cell #: ______________________________________

Email Address: ____

How did you hear about Velocity Care? ☐Billboard ☐Doctor Referral ☐Clinic Sign ☐Newspaper ☐Mailer ☐Phonebook ☐Friend/Relative ☐Insurance ☐Been here before ☐Internet

Person to contact in case of Emergency: ______________________________ Phone #: _______________

GUARANTOR/RESPONSIBLE PARTY (if patient is under 18)

Relationship to Patient : ☐Spouse ☐Parent Other : ______________________________

Name: Last ______________________________ First ____________________________ MI _________

Social Security # _________________________ Date of Birth: _______________ Gender: ☐Male ☐Female

Address:____

City: _________________________________ State: ___________________ Zip: __________________

Home #: ______________________________ Cell #: ____

INSURANCE INFORMATION

Insurance Company: ___________________________________ Policy #: _________________________

Policy Holder: (if different from self)

Name: Last ______________________ First ___________________________ MI _________

Social Security # ________________________ Date of Birth: _______________ Gender: ☐Male ☐Female

Address:____

City: ______________________________________ State: _______________ Zip: __________________

Home #: ______________________________ Cell #: _______________________________________

If you have a secondary insurance, please let the receptionist know. Thank you.

CONSENT FOR TREATMENT

I voluntarily present for treatment and consent to the physician and whomever they may designate as their assistant, associate, treating physician and patient care staff to provide my care. Such care may include, but not limited to, diagnostic procedures, psychotherapeutic treatment, other treatment and medications, pathologic and radiological evaluations and procedures considered advisable in my diagnosis, treatment, and course of care. I recognize it is the responsibility of my physician to explain to me the nature of any diagnostic test and medical and/or surgical procedures judged by them to be necessary for my treatment and to advise me of risks and consequences of such procedures. I acknowledge that no guarantees have been made to me as to the result of any treatments, examinations, and/or operative procedures performed at Velocity Care Urgent Treatment Center.

RELEASE OF MEDICAL INFORMATION:

I hereby authorize the physician involved with my care to release information from my medical record as may be required to any person, corporation, or agency which is legally responsible or has good cause to believe is legally responsible for processing and/or paying all or any part of the physician's charges and/or professional fees which incur.

ASSIGNMENT OF BENEFITS:

In consideration of services provided by Velocity Care Urgent Treatment Center, I hereby assign and transfer any and all rights, which I have against insurance companies, governmental agencies, or third party payers, for payment of charges for services provided to me or one of my dependents. I understand that I am responsible for and will pay the portion of my bill not covered in accordance with the regular rates and terms of Velocity Care. I further agree to pay the amount in full upon receipt of my billing statement unless payment arrangements are made. I authorize payments to be applied to any unpaid balance for which I am responsible. If my account is placed with a collection agency, an additional 25% will be added to my balance.

RECEIPT OF HIPPA PRIVACY NOTICE:

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how Velocity Care Urgent Treatment Center may use and disclose my protected health information. I understand that Velocity Care Urgent Treatment Center reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

____ ____________________

Patient/Responsible Party Signature Date

ALTERNATIVE CONTACTS AND TREATMENT FORM

We at Velocity Care Urgent Treatment Center take your medical confidentiality very seriously. We will not and cannot release information without your written authorization.

This authorization allows our staff members to speak only with individual(s) you designate in the event you are not available to receive phone calls or you have an adult member that helps coordinate your medical care. You should not designate your doctor.

As part of our Patient Privacy Policy, we will not leave any health information with any other person unless you specifically authorize below:

_____ I do **not** authorize anyone to receive information regarding my medical care.
_____ I authorize my physician and the employees of this clinic to speak with:

1. Person:_______________________________________ Relationship:_____________________________
   Phone number(s):____
   ☐ appointments ☐ account/bill ☐ lab results ☐ test results ☐ medical care ☐ treatment

2. Person:_______________________________________ Relationship:_____________________________
   Phone number(s):____
   ☐ appointments ☐ account/bill ☐ lab results ☐ test results ☐ medical care ☐ treatment

Alternate means of contacting me are:

Cell Phone: _______________________________ My Fax number: ___________________________
My answering machine/voicemail/pager: ____
Email: ____
Other: ____

This authorization will remain in effect unless changed by me while I am a patient at this office. It is my responsibility to notify this office of changes and to complete a new form. Any problems and/or questions concerning this form are to be referred to the Velocity Care Office Manager.

I agree that should I desire to revoke this authorization, I will give written notice.

_______________________________________ _______________________________________
Patient Signature Parent/Guardian Signature

_______________________________________ ________________ ________________
Witness Signature Date Time

Velocity Care Urgent Treatment Center

Patient Name: ______________________________ Date of Birth: ______________

What is the reason for your visit today? ____

Is this condition related to a work accident or car accident? Yes / No

Please check the symptoms you are being seen for *TODAY*.

Constitution
Fever Chills
Sweats Tired
Weight Loss

Neurological
Headache
Weakness
Poor balance
Numb Tingling

ENT
Sinus Pressure
Tooth pain
Hoarse voice
Sore throat
Facial pain
Ear pain
Runny nose
Poor hearing

Eyes
Eye pain Red eyes
Blurry vision
Eye discharge

Skin
Rash Itching
Bites Sores
Redness

Musculoskeletal
Muscle Pain
Joint Pain

Cardiac
Chest pain/ pressure
Light headed
Fainting
Fluttering in chest
Swelling of legs/ feet

Respiratory
Short of breath
Dry cough
Productive cough
Wheeze

Gastrointestinal
Belly pain
Vomiting Nausea
Diarrhea

Genitourinary
Painful urination
Bloody urination
Frequent urination
Waking up to urinate
Irregular periods
Itching
Pain
Discharge
History of STD

Psych
Depressed
Anxious
Difficulty sleeping

Allergy
Itchy eyes
Sneezing
Frequent infections

Females Only
Date of Last Period:
____
Currently Pregnant
weeks ________
Hysterectomy
Tubal
Post Menopausal

Tobacco Use:
Never
Quit (Year: ________)
_____ Cigarettes/day
Chew/Snuff

Alcohol Use:
Never
Socially
_____ drinks/day

Allergies: ______________________________
____
____
No Allergies

Current Medications: ____
____
____

Preferred Pharmacy (name & location) : ______________________________

Consent for services and/ or disclosure of Protected Health Information: I hereby consent to medical evaluations, testing and/or treatment provided to me by the staff of Velocity Care Urgent Treatment Center. I also understand that Velocity Care may use or disclose any Protected Health Information (PHI) necessary to carry out treatment, payment or healthcare operations. I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

______________________________ ______________
Signature of patient or parent/guardian of minor Date