hoover urgent care
2503 Highway 150, Suite 105
Hoover, AL 35244
Phone: (205) 987-6801
Fax: (205) 987-6810

Please complete paperwork in its entirety

PATIENT INFORMATION

Name (First, Middle Initial, Last)_____ **Date of Birth** ___/___/___
Address_____ **Apt#**____ **Home #** _____
City_____ **State**_____ **Zip**_____ **Work #** _____
Social Security # ___-___-_____ **Gender:** ☐ Male ☐ Female **Cell #** _____
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Other:_____ **Email** _____
Best Form of Contact: ☐ Home ☐ Cell ☐ Email ☐ Other:_____ **PCP** _____
Race _____ ☐ Prefer not to answer **Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Child ☐ Student ☐ Other:_____
Employer_____ **Pharmacy Name & Phone #**_____
Reason for Visit: ☐Cold/Cough/Fever/Sore Throat ☐Ear Problem ☐Injury:_____ ☐UTI/Bladder
☐Skin Infection/Rash ☐Eye Infection ☐Stomach Pain/Nausea/Vomiting ☐Other:_____

RESPONSIBLE PARTY INFORMATION

(Person responsible for a patient under the age of 18)

Name_____ **Date of Birth**___/___/___
Address (if different than patient)_____
City_____ **State**_____ **Zip**_____ **Phone #**_____

INSURANCE INFORMATION

Insurance Subscriber: ☐ Patient ☐ Responsible Party ☐ Other: **Name**_____
Date of Birth___/___/___ **Phone #**_____
Address (if different than patient)_____
Name of Insurance_____
Contract/ID #_____ **Group #**_____

I have read and accept the HIPAA Agreement ☐ Yes ☐ No **Notice of Privacy Practices** ☐ Yes ☐ No

I consent to treatment for myself or above minor child. I understand that the examination and/or medical treatment I will receive is NOT intended to replace complete medical care by my personal primary care physician. I am aware that I will be responsible for copayment or full payment at the time of service. Any pre-certification requirement that my insurance company requires is my responsibility to make. Furthermore, I allow Hoover Urgent Care to release to my insurance company treatment and billing information, as requested, to process my claim. I allow Hoover Urgent Care to accept assigned payments made by my insurance company on my behalf. I understand that by my lack of payment or if my insurance denies payment, I am responsible for payment in full for services rendered. My failure to pay may result in collection proceedings. In addition, I authorize Hoover Urgent Care to release to my primary care physician or specialty referral, any and all information related to my treatment at this clinic.

_____ _____
Patient Signature or Parent of Minor **Date**

Please sign ALL pages →

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Insurance/Billing/HIPAA

On August 21, 1996, President Clinton signed the Health Insurance Portability and Accountability Act, known as HIPAA. This law impacts all areas of the health care industry and was designed to improve the efficiency of health care by standardizing the exchange of administrative and financial data, and to protect the privacy, confidentiality and security of health care information.

A major concern in the law was the security and privacy of electronic health records and their transmission between health care entities. The security consists of more than just firewalls – organizations must ensure the confidentiality and integrity of their health records, and transmission of data must be authenticated and have the property of non-repudiation. Additionally, security policies and procedures must be documented and implemented. Hoover Urgent Care has taken a number of technological and administrative steps in order to protect such data. Hoover Urgent Care has a policy requiring all employees to read and sign a confidentiality agreement. This agreement states that the employee understands that we process confidential data, and that the employee agrees not to directly or indirectly disclose any information in an inappropriate manner. Hoover Urgent Care aggressively enforces this and other agreements applicable to confidential data. Confidentiality obligations are also an integral part of our business and trading partner agreements with entities to which we transmit transactions or from which we receive transactions, such as clearinghouses. Hoover Urgent Care will neither pursue nor knowingly retain a customer relationship with an entity that is either unwilling or unable to concur with reasonable privacy and confidentiality obligations.

Hoover Urgent Care recognizes that the transfer of medical data must be carried out in a manner that minimizes the risks of inappropriate disclosure and that safeguards the privacy and confidentiality of data that may identify individuals in their roles as patients and consumers. Hoover Urgent Care's corporate policy is to observe all existing state and federal laws and regulations relating to the transmission, storage, and access to records and other health care data, and to maintain the security and confidentiality of patient-specific information.

The physicians of this office are contracted with many of the local and national managed care plans. However, there are some plans that we do not currently have contracts with. If you belong to a plan that we are not contracted with, our insurance/billing office will be glad to file a claim for you with the understanding that full payment is due at the time of service. Your claim will probably be applied to an out-of-network deductible or totally rejected.

It is important for you to understand that the patient is ultimately responsible for the fees that are not covered by the provider in this case. If you have any questions concerning the coverage your plan has with Hoover Urgent Care, please call the patient relations department of your provider.

The responsible party will also be responsible for any durable medical equipment (splints, crutches, ace wraps, etc.) and medications not covered by the insurance plan or applied towards the deductible. *This is also applicable to items not covered by Medicaid.* **These will be payable at time of service.**

All HMO/**Community Care (Medicaid)** members are required to contact their primary care physician for obtaining a referral within 48 hours. This referral must be sent to Hoover Urgent Care – Insurance/Billing office within this time frame for your claim to be filed through your insurance. The patient will be responsible and billed for the balance due, if this process is not followed.

Thank you

_____ Printed Patient Name

_____ Signature of Patient or Guardian

Hoover Urgent Care

E-Mail Consent Form

Patient Name:	
Account Number:	Date of Birth:

Please read the following statements carefully:

RISKS OF USING E-MAIL. Transmitting patient information by E-mail has many significant risks that you should consider before asking us to use E-mail as a means of communicating your personal health information. These risks include, but are not limited to, the following:

- E-mail can be circulated, forwarded and stored in numerous paper and/or electronic files without your knowledge;
- E-mail can be sent immediately worldwide and received by large numbers of unintended individuals;
- E-mail addresses can be misaddressed causing the information to be sent to the wrong individuals; or
- E-mail can be intercepted, changed and redistributed to others.

CONDITIONS FOR USE OF E-MAIL. We will use reasonable means to protect the security and confidentiality of E-mail sent and received. However, because of the risks, some of which are outlined above, we cannot guarantee the security and confidentiality of E-mail communications, and will not be responsible for improper disclosures of your health information. Accordingly, you must consent to the use of E-mail for sending your personal health information. Consent to the use of E-mail includes your agreement with the following conditions:

- All E-mails concerning your diagnosis or treatment will be printed out and made part of your medical record. Because they are a part of the medical record, other individuals authorized to access the medical record will have access to these E-mails;
- We may forward E-mails internally to our staff and agents as necessary for diagnosis, treatment, reimbursement, and other appropriate purposes. We will not, however, forward E-mails to independent third parties without your prior written consent, except as authorized by law;
- We cannot guarantee that any particular E-mail from you will be read and responded to within any particular time. Thus, you should not use E-mail for medical emergencies or other time sensitive matters;
- If your E-mail requires or invites a response from us, and you have not received a response from us within a reasonable period of time, it is your responsibility to follow-up to determine whether the intended recipient received the E-mail and when the recipient will respond;
- You should not use E-mail for communication of sensitive medical information including, without limitation, sexually transmitted diseases, HIV/AIDS, mental health conditions, substance abuse or other developmental disabilities;
- You are responsible for informing us of any type of information that you do not want sent by E-mail;

- We shall not engage in unlawfully practicing medicine across state lines; and
- We will not be responsible for the occurrence of any of the items set forth in Paragraph 1 above.

BY SIGNING THIS FORM, I HEREBY ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THIS CONSENT TO USE AND/OR DISCLOSE MY HEALTH INFORMATION VIA E-MAIL. I UNDERSTAND THE RISKS AND CONSENT TO THE CONDITIONS OUTLINED HEREIN AND ANY OTHER INSTRUCTIONS OR CONDITIONS HOOVER URGENT CARE MAY IMPOSE CONCERNING THE USE OF E-MAIL COMMUNICATIONS.

_____ _____

Signature of Patient or Patient's Representative Date

_____

Printed Name of Patient's Representative (*if applicable*)

_____

Representative's Relationship to Patient (*if applicable)*

Hoover Urgent Care

Patient Authorization for Use and/or Disclosure of Protected Health Information

Patient Name:	Date of Birth:
Address:	Account Number:

I hereby authorize Hoover Urgent Care ("Hoover Urgent Care") to use, disclose and/or obtain the above-named patient's health information as follows (*check all that apply*):

□ **use the following health information maintained by Hoover Urgent Care until:** _____ **Expiration Date/ will expire one year from signed date unless otherwise specified above.**	□ **disclose the following health information to:** _____ **Address:** _____ **City, State, Zip:** _____ **Phone:** _____	□ **obtain the following health information from:** _____ **Address:** _____ _____ _____

Specific description of the health information to be used/disclosed/obtained (*include dates of service, i.e., appointment date, type of service, etc):* _____

_____

_____

This health information is used/disclosed/obtained for the following purpose (*if Authorization requested by the patient put: "At the request of the individual"*): _____

_____

By providing this Authorization, I understand as follows:

1. **I understand that this Authorization may result in the sending of clinical information and x-rays with reference to the above-named patient's diagnosis and/or any alcohol, drug or child abuse problems, behavioral or mental health services, and/or information concerning sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency syndrome (HIV). I understand that these records are strictly confidential and are solely for the information of the person to whom addressed.**

2. I understand that this Authorization is voluntary. I may refuse to sign this Authorization and the above-named patient's treatment and/or payment obligations will not be affected unless either of the following applies:

   - The treatment is related to research and the use and/or disclosure is related to such research; or
   - The treatment is solely for the purpose of creating protected health information for disclosure to a third-party.

3. I understand that Hoover Urgent Care may receive financial or in-kind compensation or remuneration in exchange for the use and/or disclosure of the above-named patient's protected health information.

4. I understand that the health information to be released may be subject to redisclosure by the recipient of the health information and no longer protected by federal or state law.

5. I understand that this Authorization is continuous in nature and is to be given full force and effect, including disclosing and/or utilizing any and all of the foregoing information learned or determined after the date hereof but prior to the expiration date noticed below.

6. I understand that I may revoke this Authorization at any time by notifying Hoover Urgent Care in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation. Unless otherwise revoked, this Authorization will expire on _____ (date, event, or condition). If I fail to specify a date, event, or condition, this Authorization will expire in one (1) year.

7. I understand that, upon request, I may receive a copy of this Authorization form after I sign it.

8. I understand that a photocopy or facsimile of this Authorization shall be valid and effective, just as the original.

Signature of Patient or Patient's Representative

Date

Printed Name of Patient's Representative (*if applicable*)

Representative's Relationship to Patient (*if applicable*)

BY SIGNING BELOW, I HEREBY ACKNOWLEDGE RECEIPT OF THE CLINIC'S NOTICE OF PRIVACY PRACTICES.

_____ _____

Printed Name of Patient Date

_____

Signature of Patient

_____

Printed Name of Parent/Patient's Representative (If Applicable)

_____

Signature of Parent/Patient's Representative (If Applicable)