IMMEDIATE CARE

PATIENT REGISTRATION FORM

PATIENT DATA

PATIENT LAST NAME **FIRST** **MI** ☐ FEMALE ☐ MALE BIRTH DATE AGE HOME PHONE

ETHNICITY

☐ WHITE/NON HISPANIC ☐ BLACK/AFRICAN AMERICAN ☐ AMERICAN INDIAN OR ALASKAN NATIVE

☐ HISPANIC ☐ ASIAN OR PACIFIC ISLANDER ☐ OTHER_____

ADDRESS SOCIAL SECURITY NO. MARITAL STATUS ○S ○M ○W ○D CELL PHONE

CITY STATE ZIP ARE YOU EMPLOYED? ☐ YES ☐ NO EMPLOYER NAME OCCUPATION

EMPLOYER ADDRESS WORK PHONE

WHO CAN WE CONTACT IF WE ARE UNABLE TO REACH YOU? RELATIONSHIP PHONE

PERMISSION TO RELEASE MEDICAL INFORMATION TO RELATIONSHIP

INSURANCE

INSURANCE COMPANY PRIMARY **EFFECTIVE DATE**

POLICY/ID # GROUP # PHONE

POLICY HOLDER

SS #

DATE OF BIRTH SEX Female

RELATIONSHIP TO PATIENT

INSURANCE COMPANY SECONDARY

POLICY/ID # GROUP # PHONE

POLICY HOLDER

SS #

DATE OF BIRTH SEX Female

RELATIONSHIP TO PATIENT

WORKERS COMP.

HOW DID INJURY OCCUR? **DATE OF INJURY** **DOES YOUR EMPLOYER KNOW?**

☐ WORK ☐ MVA ☐ OTHER ☐ YES ☐ NO

IF WORKERS COMP., INS. CARRIER NAME & ADDRESS (WHERE TO SEND CLAIMS) CITY, STATE, ZIP PHONE

EMPLOYER NAME & ADDRESS: (WHEN INJURY OCCURRED) CITY, STATE, ZIP INJURY CLAIM # EMPLOYER POL #

MVA

IF MVA, INS. CARRIER NAME AND ADDRESS **INJURY CLAIM #**

PHARMACY NAME

ADDRESS

PHONE

PRIMARY CARE PHYSICIAN

ADDRESS

PHONE

A summary of your visit will be sent to your Primary Care Physician

REASON FOR VISIT

EMAIL ADDRESS *

☐ **Yes, I would like to receive Immediate Care news & emails**

HOW DID YOU HEAR ABOUT US? (CIRCLE ONE) ○FRIEND/FAMILY ○IMMEDIATE CARE STAFF ○PHYSICIAN REFERRAL ○EMPLOYER ○COMMUNITY EVENT ○SOCIAL MEDIA ○DIRECT MAIL ○PRINT AD ○RADIO ○BILLBOARD ○DIGITAL AD ○OTHER:_____

PATIENT SIGNATURE x

DATE

HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF PHI & ACKNOWLEDGEMNT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

1. I hereby authorize Urgent Care Physicians of New Jersey LLC ("UCPNJ") as a covered entity (CE) to use and/or disclose my protected health information* ("PHI") with/to (check as applicable):

☐ my spouse, i.e._____;

☐ my adult child, i.e._____;

☐ my employer, i.e. _____; and/or

☐ other (please specify): _____.

2 The PHI that may be so used and/or disclosed by UCPNJ is:

(a) ☐ ***all*** PHI in my medical record maintained by UCPNJ; **OR**

(b) ☐ the PHI in my medical record maintained by UCPNJ *with the* ***exception*** *of information concerning* (check as applicable):

☐ psychological, psychiatric or other mental impairment(s);
☐ drug abuse, alcoholism, or other substance abuse;
☐ sickle cell anemia;
☐ human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome (AIDS) or tests for HIV);
☐ sexually transmitted diseases;
☐ communicable diseases;
☐ gene-related impairments (including genetic test results); and/or
☐ other (please specify): _____.

3. The PHI may be used and/or disclosed for the following purposes: my medical treatment, UCPNJ obtaining payment for the health care provided to me, the general health care operations of UCPNJ (e.g. quality assessments, competency assurance activities, and business management) and other purposes as I may direct.

4. This authorization shall remain in effect until *either* revoked as provided for below *or* two (2) years from the date of my signature below.

5. UCPNJ as a CE receiving health information under this authorization will *not* receive direct or indirect remuneration in exchange for disclosing the health information for the purposes of marketing, the sale of the PHI, or research.

6. I understand that my treatment will *not* be conditioned on whether I sign this Authorization.

HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF PHI & ACKNOWLEDGEMNT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

7. I understand that, as set forth in the notice of privacy practices of UCPNJ, I have the right to revoke this authorization, in writing, at any time, except to the extent that UCPNJ has acted in reliance upon it, by sending written notification to:

Office Of HIPAA Information and Complaints
Urgent Care Physicians of New Jersey LLC
c/o Immediate Care Walk-In Management, LLC**
46 Newman Springs Road East
Red Bank, New Jersey 07701

8. I understand that I have the right to refuse to sign this authorization.

9. I understand that PHI used or disclosed pursuant to this authorization may be redisclosed by the recipient and its confidentiality may no longer be protected by federal or state law.

10. I hereby acknowledge that I have received the UCPNJ NOTICE OF PRIVACY PRACTICES as (a) presented in the waiting area and exam rooms of UCPNJ and (b) a copy handed to me upon request.

_____
Signature of Patient / Representative

_____
Printed Name of Patient

_____
Printed Name of Representative of Patient (if applicable)

Date: _____

_____
Relationship of Representative to Patient

* "Protected health information" (PHI) includes information that relates to an individual's past, present or future physical or mental health or condition, the provision of health care to an individual, or, the past, present or future payment for the provision of health care to an individual and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual (e.g. name, address, birth date or social security number). 45 C.F.R. Sec. 160.103.

** *Immediate Care Walk-In Management, LLC and its certain affiliates are each a medical management service company providing management and administrative services to urgent care and primary care medical practices. The health care providers of the medical practices have complete and sole authority regarding patient care and medical decision making.*