emediate cure
QUICK CARE

# Patient Registration Form

Open Everyday • 9 am to 9 pm.

**PATIENT INFORMATION :**

First ______________ MI ____ Last ______________ Gender M / F

Date of Birth _____/ _____/ _________ Social Security# ________ - ________-__________

Mailing Address ______________________________ Apt/Unit #__________

City ______________________________ State__________ Zip ______________

Home Phone (_____) __________-______________ Cell Phone (_____) ____________ - ______________

Email ______________________________ @ ____________________

PLEASE PRINT Providing your email above will allow use for Health communications and Billing, we will not distribute to third parties.

**EMERGENCY CONTACT**

Name ______________________ Phone ________________ Relationship__________

**PREFERRED Pharmacy**

Name ______________________ Location ______________________

☐ **NO INSURANCE / PROMPT PAY**

**PRIMARY** Insurance Company______________________________

Guarantor's name (if not patient)______________________ D.O.B. ______________

Relationship to Patient ______________________

☐ **NO SECONDARY**

**SECONDARY** Insurance Company______________________________

Guarantor's name (if not patient)______________________ D.O.B. ______________

Relationship to Patient ______________________

**IF PATIENT IS UNDER - Parent/Guardian**

First Name ______________ MI _____ Last Name ______________ Gender M / F

Relationship to patient ______________ Social Security# __________-______-_________ D.O.B._________ /____ /_______

Address ______________________ Apt# _______City ______________ State___ Zip _________

☐ Address same as above Cell Phone (____)_______-____________ Home Phone ( _____) _________-______________

**Consent for services and disclosure of Protected Health Information**

I hereby consent to medical evaluations, testing and/or treatment provided to me by the staff of Emediate Cure Quick Care. I also understand that Emediate Cure Quick Care may use or disclose any Protected Health Information (PHI) necessary to carry out treatment, payment or healthcare operations. I authorize 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 the payment of insurance benefits, otherwise payable to me, to be paid directly to Emediate Cure Quick Care and I agree to pay any remaining balance once my insurance plan has processed my claim. I understand that I am responsible for any balance remaining due within 30 days of the first billing date. Any balance remaining after 30 days will be considered past due, I agree to pay interest at the rate of 18% per annum (1.5% monthly) on the balance due. Furthermore, in the event that my balance becomes past due Emediate Cure Quick Care has the right to refer any unpaid balance on my account to an attorney for collections and that in addition to any unpaid balance, I may be held responsible for the costs of collection including, but not limited to, fees of 30% of the unpaid balance, court costs and attorney's fees.

X ______________________________ Print Name______________________ Date __________

Signature of patient or parent/guardian if minor

# NOTICE OF PRIVACY POLICIES FOR Emediate Cure Quick Care
## HIPAA Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**
Initial Publication: 7/2015

You are coming to us, Emediate Cure Quick Care, to receive medical care. The law requires us to protect the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect lo this health information. This Notice of Privacy Practices outlines out legal obligations regarding your health information. Please read it carefully and ask us if you have any questions.

**1. Uses and Disclosures of Protected Healthy Information**

We collect health information from you and store it in medical records or otherwise in our systems. This record contains your symptoms, examination and test results, diagnoses, treatment, and plan for future care or treatment. The law protects all information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. Consistent with applicable laws, this information serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A source of information for public health officials in charge of improving the health of this state and the nation,
- A tool in educating health professionals
- Legal Document describing the care you received,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding who, what, when, where, and why others may access your health information, will help you to make more informed decisions when authorizing disclosure to others.

The law allows us to use or disclose your health information for the following purposes:

*We may use your health information to provide you with medical treatment or services.*
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

*We may use and disclose your health information for purposes of receiving payment for treatment and services that you receive.*
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, we may send a bill for your services to your health insurance company, and this bill may contain certain information such as your name, diagnosis, procedures, supplies, and the service we provided to you.

*We may use or disclose, as needed, your protected health information in for Health Care Operations.*
We may use and disclose your health information for the operation of our facility. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

*Business Associates:* There are some services provided in our organization through contacts with business associates. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

*Notification:* We may also disclose your health information to notify or assist in notifying a family member, your personal representative, or other persons responsible for your care about your location, general condition, or death.

*Communication with Family and Friends:* We will disclose your health information to your family members and friends if you are in our facility and conscious and you allow such a disclosure or it is reasonable to assume from the circumstances that you allow the disclosure. If you are not in our facility or you are incapacitated, our health care practitioners will exercise professional judgment to determine whether a disclosure to your family, personal representative or other persons responsible for your care is in your best interests. The practitioner will only disclose information directly relevant to the recipient's involvement in your health care or payment for your health care.

*Public Health Agencies:* We may use or disclose your health information for public health activities such as assisting public health authorities in preventing or tracking disease and maintaining customer records of medical supplies in the event of product recall. We are required to report initial diagnosis of sexually transmitted diseases and communicable diseases to state public health agencies.

*Health and Safety and Law Enforcement:* We are required to disclose information to law enforcement if we suspect child abuse or neglect. In the exercise of our professional judgment, we may report information in the case of adult abuse. Your health information may also be disclosed to avert a serious threat to health or safety of you or any other person. Finally, we may disclose health information to assist law enforcement officials In their duties.

*Required by Law:* We will disclose health information if we are required to by law, such as pursuant to a judicial or administrative subpoena. We may also be required to disclose information for specialized government functions such as protection of public officials or reporting to various branches of the armed services.

*Marketing:* We may contact you to provide information about treatment alternative, fund raising or other health-related benefits and services that may be of interest to you. We might also send you general newsletters or other information that promotes your health as well as other helpful information regarding our facility.

*Funeral Directors* Health information may be disclosed to funeral directors or coroners to enable such persons to perform their duties.

*Organ procurement organizations:* Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

*Research:* We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

*Workers compensation:* We may disclose health information to the extent authorized by and to the extent necessary to comply with las relating to workers compensation or other similar programs established by law.

*Military:* Our practice may disclose your information if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

*National Security:* Our practice may disclose your health information to Federal officials for intelligence and national security activities authorized by law. We may also disclose your health information to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

**Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent we have taken action in reliance upon the authorization.**

**Your Rights Regarding Your Health Information**

You have certain rights with respect to your health information. They are listed below. If you would like to exercise any of these rights or if you have questions regarding these rights, please contact our **Privacy Officer at 815-733-5952**. You also have the right to file a complaint with the Dept. of Health and Human Svc. or *Office for Civil Rights*. There will be no retaliation for filing a complaint with either the Privacy Officer or the *Office for Civil Rights*. You have the right to:

- Request that we communicate with you through alternative means or locations, and we will respect any reasonable requests.
- Review and obtain a copy of your health information. We have the right to charge you a fee for the cost of providing you with such a copy.
- Request that we amend your health information. This request must be done in writing and approved by the physician. We will review your request but not necessarily make the amendments you requested.
- Obtain an accounting of disclosures that we have made of your health information except disclosures for treatment, payment, health care operations, disclosures authorized by you, and disclosures for certain government functions.
- Revoke any authorization you made for the use or disclosure of your health information except to the extent we have already relied on the authorization.
- Receive a paper copy of this notice.
- Request that we limit our uses and disclosures of your health information, as you specify. We may not agree to your request.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at this time. We reserve the right to change the terms of this Notice of Privacy Practices and to make the new terms effective for all health information we possess. We will communicate any changes by providing you with a new copy of the Notice of Privacy Practices the next time you receive treatment at our facility after any such change. We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at 815-733-5952.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

X ______________________________ Print Name ______________________ Date __________

Signature of patient or parent/guardian if minor