Urgent Care

PATIENT DEMOGRAPHICS

2507 Eastbluff Drive
Newport Beach, CA 92660
Ph: 949.200.1655 Fx: 949.200.1650

How did you hear about us?

(check one): ☐ Referred by Patient: _____ ☐ School ☐ Employer ☐ Doctor ☐ Insurance
☐ Google ☐ Yahoo ☐ Yelp ☐ Other _____ ☐ Drive by ☐ Walk by ☐ Other: _____

Social Security Number: _____

Sex (check one): ☐ Male ☐ Female Date of Birth: _____ Age: _____

Last Name: _____ First Name: _____ MI: _____

Address: _____ Apt#_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone (Ages 18+ only): _____

Email: _____ Permission to receive informational emails? ☐ Yes ☐ No

Marital Status: (check one): ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Race: (check one): ☐ American Indian ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ White ☐ Decline

Ethnicity: (check one): ☐ Hispanic/Latino ☐ Not Hispanic ☐ Decline Preferred Language: _____

Who is Your Primary Care Physician? (Physician seen in the last two years for routine/primary care)

Name: _____ Specialty? ☐ Internal ☐ Peds ☐ GP/Fam ☐ OBGYN ☐ Other _____

City _____ Phone: _____ Fax: _____

Would you like us to send them a courtesy summary of today's visit notes for your chart there? (check one): ☐ Yes ☐ No

Emergency Contact:

Name: _____ Phone: _____

Relationship to Patient: (check one): ☐ Spouse ☐ Parent ☐ Sibling ☐ Other: _____

Patient Record of Disclosures / Acknowledgement of Notice of Privacy Practices

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I acknowledge that a copy of the current Notice of Privacy Practices is posted in the reception area and that I can request a copy for my personal use at any time.

Indicate your preferred method of communication with us. (check one): ☐ Home Phone ☐ Cell Phone ☐ Email
Indicate your message preference. (check one): ☐ OK to leave detailed message ☐ Leave call-back number only ☐ OK to text
I agree to enroll in "Vital Chat" in order to communicate with Vital Urgent Care via text message. (check one): ☐ Yes ☐ No

Signed: _____ Date: _____

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Insurance Information

(check one): ☐ Health Insurance ☐ No Insurance / Self Pay ☐ Employer Paid Service ☐ Worker's Compensation

Financially Responsible Party (check one): ☐ Patient/Self ☐ Spouse ☐ Mother ☐ Father ☐ Other: _____

Insurance subscriber (check one): ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Other: _____

Insurance Carrier Name: _____

Insurance Holder's Name: _____ Insurance Holder's Date of Birth: _____

Address (if different from above): _____ Apt#:_____

City: _____ State: _____ Zip Code: _____

Insurance Holder's Phone (if different from above): _____ Cell Phone: _____

Patient's Financial Responsibility Statement

INSURANCE COVERAGE

We do our best to only accept patients' insurance plans that we are contracted with, but it is ultimately the responsibility of the patient to fully understand their plan's benefits including coverage, deductibles, co-payments, co-insurance and participating provider network. **I understand my plan details and accept financial responsibility for all services received, including any charges not covered by my insurance.** Initial: _____

INSURANCE OR SELF-PAY

If your insurance has a high deductible or co-insurance, you may choose to not bill your insurance and pay the Self-Pay price instead. You must decide this before receiving services. Self-Pay fees are due up front at the time of service and no insurance billing will be done on your behalf later. Self-Pay is not an option retroactively or once you have chosen to proceed under your insurance plan.

(check one):

☐ **I wish to use my health insurance. I authorize payment of insurance benefits directly to Vital Urgent Care.** Initial: _____

☐ **I DO NOT want to use insurance. I wish to Self-Pay for this visit instead.** Initial: _____

CREDIT CARD ON FILE & PAYMENT AUTHORIZATION FOR PATIENTS REQUESTING INSURANCE CARRIER BILLING

Vital Urgent Care will bill your insurance on your behalf. However, in order to reduce costs associated with collecting any balances remaining after insurance payment, we request authorization to maintain a credit card or debit card on file to cover amounts determined by your insurance to be your responsibility. **Credit card information is obtained anew for each visit and is a requirement to be seen for patients requesting billing to their insurance.**

After your insurance has processed and paid your claim, any unpaid portion of your claim will be billed to your credit card or debit card held on file. You will receive an email notice 7 days prior to your credit or debit card being charged. The *maximum* charge allowed is $250 per 30 day period. When you receive your notice, you have the option of stopping the automatic payment or of changing the method of payment. All credit/debit card information remains *confidential* and *securely stored* by **First Data** using bank-level encryption for a period of 90 days, and is then deleted. Vital Urgent Care ***does not*** store any banking information.

We require a valid email address on file in order for you to receive the advance email notice before your credit card is charged.

I authorize Vital Urgent Care to charge any and all outstanding balances *(under the terms described above)* after insurance company reimbursement or denial, to my credit/debit card. This authorization also covers future visits in which my credit card information is obtained. I understand that I will not receive a statement if there is no balance due after processing my credit card for payment.

_____ _____

Cardholder's Authorization Signature Date

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Physician-Patient Arbitration Agreement

Article 1: Agreement to Arbitrate. It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must Be Arbitrated. It is the intent of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including without limitation, claims for the loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law. A demand for arbitration must be communicated in writing to all parties. Each party shall an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory common law.

Each party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to healthcare providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgement or summary adjudication in accordance with Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions. All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation. This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect. If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to emergency treatment) patient should initial below. If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in effect and shall not be affected by the invalidity of any other provision**.**

Effective as of the date of first medical services: _____
Patient's or Patient's Representative's Initials

I understand that I have a right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I was offered a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ Date: _____
Patient's or Patient's Representative's Signature

By: _____
Print Patient's Name

(A signed copy of this document is to be given to the patient upon request. Original to be filed in patient's chart.)

VIDAL Urgent Care

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PATIENT DEMOGRAPHICS

Health Questionnaire

Patient Name:_____ DOB:_____

Any Medication Allergies? ☐ Yes ☐ No _____

Any Food Allergies? ☐ Yes ☐ No _____

Are You Currently Taking Any Medications? ☐ Yes ☐ No

What are they, how much and how often? _____

_____

_____

_____

Medical History: (circle *ALL* that apply)

Arthritis: Osteoarthritis Rheumatoid Psoriatic
GI: Esophageal Reflux Esophageal Varicies Gastric Ulcer Hemorrhoids Pancreatitis
***Liver*:** Gall Stones Jaundice Cirrhosis Hepatitis A Hepatitis B Hepatitis C
***Bowels*:** Colitis Diverticulosis Diverticulitis Irritable Bowel Syndrome Colon Polyp Crohn's Disease
Blood: Anemia Coagulopathy Platelet Disorder Multiple Myeloma Leukemia Lymphoma HIV/AIDS Thrombosis DVT
Cancer: *Type*: _____ When? _____
Diabetes: Type I Type II
ENT: Chronic Otitis Media Allergies Chronic Rhinitis Allergic Rhinitis Chronic Sinusitis
Mouth/Throat: Dental Caries Gingivitis Chronic Cough Chronic Laryngitis Sleep Apnea
GU: Prostatitis Varicocele Incontinence
Heart: Heart Attack Angina Heart Murmur Cardiomyopathy Abnormal Rhythm Heart Failure Myocarditis Endocarditis
High Blood Pressure: *Range*: _____ *Controlled?* ☐ Yes ☐ No
High Cholesterol? ☐ Yes ☐ No
Lung: COPD Asthma Cystic Fibrosis Tuberculosis Alpha 1- Antitrypsin Deficiency Pneumonia Pneumothorax Pulmonary Embolism
Kidney: Renal Artery Stenosis Kidney Failure Dialysis
Musculoskeletal: Gout Lupus Osteoporosis Fibromyalgia Chronic Back Pain Chronic Neck Pain Chronic Joint Pain
Neurological: Alzheimer's Bell's Palsy Vertigo Cerebral Aneurysm Cerebral Palsy Dementia Parkinson's Meningitis Headaches Seizures multiple Sclerosis Trigeminal Neuralgia Neuropathy Stroke Transient Ischemic Attack Epidural Hematoma Subdural Hematoma
Psychiatric: Depression Bipolar Disorder Anxiety Panic Disorder Schizophrenia OCD ADD ADHD Insomnia Anorexia Bulimia
Sexually Transmitted Disease: Chlamydia Gonorrhea Syphilis Genital Herpes Genital Warts Trichomoniasis
Skin: Acne Eczema- Atopic Eczema- Allergic Contact Dermatitis Psoriasis Dermatitis
Thyroid: Hypothyroidism Hyperthyroidism

☐ **I Have No Significant Medical History**

Have you had any Surgeries? ☐ Yes ☐ No Explain: _____

Please indicate any notable Family Medical History

Father: _____ Mother: _____
Brother: _____ Sister: _____
Children: _____ Aunts/Aunts: _____
Grandparents: _____

Social History:

Do You Use Tobacco? ☐ Yes ☐ No Type: _____ Frequency: _____
Do You Drink Alcohol? ☐ Yes ☐ No Type: _____ Frequency: _____
Do You Use Any Drugs? ☐ Yes ☐ No Type: _____ Frequency: _____