Pacific Urgent Care and Wellness Center

975 Garnet Ave, San Diego, CA 92109
(858) 230-7770

Welcome to Pacific Urgent Care and Wellness Center!

Please complete and sign the following paperwork. Thank you!

Patient Name: _____ _____ _____
Last **First** **MI**

Sex: Male / Female **Date of Birth: _____/_____/_____** **SSN: _____-_____-_____**

Address: _____ **APT#**_____

City: _____ **State:** _____ **Zip Code:** _____

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

Email: _____ **Would you like access to your Online Patient Portal? Y / N**

What is your preferred method of contact? (circle one): Home Phone Cell Phone Email

Marital Status (circle one): Single Married Divorced Widowed Separated

Preferred Language: _____ *Decline* **Ethnicity:** Hispanic/Latino Not Hispanic *Decline*

Race: Asian Black/African American Indian Native Hawaiian/Pacific Islander White *Decline*

Emergency Contact - Name: _____

Relation to Patient: _____ **Primary Phone: (_____) _____-_____**

How did you hear about us? (Circle): Another patient Provider Insurance Walk By Other

INSURANCE INFORMATION

□No Insurance/ Self Pay □ I will be using my Insurance □Employer Paid Service

Primary Insurance Information
Insurance Carrier: _____
Member ID: _____
Group: _____
Last Name: _____
First Name: _____
Date of Birth: _____

Secondary Insurance Information
Insurance Carrier: _____
Member ID: _____
Group: _____
Last Name: _____
First Name: _____
Date of Birth: _____

Patient's relationship to policy holder: _____ Patient's relationship to policy holder: _____

PATIENT REVIEW OF DISCLOSURES

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.
Please indicate whether or not you would like a message to be left preferred contact method.

Check one: ☐ **O.K. to leave a message with detailed information** ☐ **Leave a call-back number only**

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that a copy of the current notice is posted in the reception area. I acknowledge that I can request a copy for my personal use at any time.
Signed: _____ Date: _____

Print Name: _____

If not signed by the patient, please indicate:

Name: _____ Relationship:_____

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HEALTH QUESTIONNAIRE

Reason for Visit Today:_____
_____

ANY MEDICATION ALLERGIES? Yes or No **If Yes** _____

Current Medications? Include Dosage: _____
_____
_____

Medical History: Please circle *ALL* that apply

Arthritis: Osteoarthritis Rheumatoid Psoriatic
GI: Esophageal Reflux Esophageal Varcies Gastric Ulcer Hemorrhoids Pancreatitis
Liver: Gall Stones Jaundice Cirrhosis Hepatitis 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
Cancer: *Type*:
Diabetes: Type I Type II
ENT: *Ears/Nose/Sinus:* 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 Murmur Cardiomyopathy Abnormal Rhythm Heart Failure Myocarditis Endocarditis
High Blood Pressure*: Range*: _____*Controlled?* Yes No
High Cholesterol? Yes or 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'
Meningitis Headaches Seizure Disorder 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 Trichomonia
Skin: Acne Eczema- Atopic Eczema- Allergic Contact Dermatitis Psoriasis Dermatitis
Thyroid: Hypothyroidism Hyperthyroidism

☐ **No Medical History** **Other (Please Specify):** _____

Past Surgeries: _____

Family History: **Father:** _____ **Mother:** _____
Brother: _____ **Sister:** _____
Children: _____ **Uncles/Aunts:** _____
Grandparents: _____

Social History: Tobacco Use Yes or No Type:_____ Frequency: _____
Alcohol Use Yes or No Type:_____ Frequency: _____
Recreational Drugs Yes or No Type:_____ Frequency: _____

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Patient's Financial Responsibility Statement

INSURANCE COVERAGE

Many changes within healthcare plans, benefits, and coverage have occurred in the past year. While we do our very best to only accept patients' insurance plans that we are contracted with, ***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.*** We are able to verify eligibility and office visit co-payments, but specific plan details are not accessible to us. If you have any questions about specific plan details or coverage, please contact your insurance before you receive any services.

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

Our Self-Pay Program is designed to help people with no insurance receive minimal necessary medical care at low cost. These are not the same services or fees that are billed to insurance when a patient has coverage. If you know your insurance has a high deductible or co-insurance, you have the option to decide prior to your visit, to not bill your insurance and pay the Self- Pay price instead. Self-Pay fees are due up front at the time of service and no insurance billing will be done on your behalf. Self-Pay is not an option retroactively or once you have chosen to proceed under your insurance plan.

I understand and wish to utilize my health insurance for these services, and I authorize payment of insurance benefits directly to Pacific Urgent Care for any services rendered. Initial: _____

I understand and DO NOT want to use insurance. I wish to Self-Pay for visit instead. Initial: _____

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

Pacific Urgent Care will submit a claim to your insurance on your behalf. However, in order to reduce the cost of billing and collecting 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. C**redit card information is obtained anew for each visit to Pacific Urgent Care and is a requirement to being seen for patients requesting billing to their insurance.**

Once your insurance has processed your claim, and we receive an **Explanation Of Medical Benefits (EOMB)** from your insurance carrier, any unpaid portion of your claim will be billed to your credit card or debit card held on file. Should your insurance pay in full, or if there is no balance remaining on your claim, no charge to your credit card will be made.

You will receive a separate notice via mail or email (if you provided one) informing you of the remaining amount and that the card on file will be charged in 7-10 days from date of notice. 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 absolutely *confidential* and *securely stored* by **First Data** using bank-level encryption for a period of 90 days, and is then deleted. Pacific Urgent Care and Wellness Center ***does not*** store any banking information and each visit requires a fresh validation of your credit card information.

I authorize Pacific Urgent Care and Wellness Center 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 judgment 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.

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

By: _____

Patient's or Patient's Representative's Signature

By: _____

Print Patient's Name