Pacific Wellness Center + Urgent Care
975 Garnet Ave, San Diego, CA 92109
(858) 230-7770

WELCOME TO PACIFIC WELLNESS CENTER + URGENT CARE

Please complete and sign the following paperwork. Thank you!

PATIENT NAME: _____ _____ _____ **SEX**: M F

Last First Middle

DATE OF BIRTH: ____/____/____ **MARITAL STATUS**: single married divorced widowed

FOR BILLING AND INSURANCE INFORMATION ONLY, PLEASE PROVIDE SSN# _____

ADDRESS: _____**APT#**_____

CITY_____**STATE**_____**ZIP CODE**_____

CELL PHONE:(_____) _____-_____ **HOME PHONE**:(_____) _____-_____ **EMAIL**: _____

Consent to leave messages: **YES / NO**

Consent to Newsletter: **YES / NO**

EMERGENCY CONTACT: Name_____ PHONE: _____

RELATION TO PATIENT: _____

PREFERRED PHARMACY:

CVS: ☐ MISSION BLVD ☐ GARNET AVE ☐ LA JOLLA BLVD ☐ EADS ☐ SANTA MONICA AVE

RITE AID: ☐ GARNET AVE ☐ NIAGARA AVE ☐ BALBOA AVE

OTHER: _____

HOW DID YOU HEAR ABOUT US? INTERNET FRIEND INSURANCE WALK BY

REASON FOR TODAY'S VISIT:_____

_____

Turn page over

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Patient's Financial Responsibility Statement

□No Insurance/ Self Pay □ I will be using my Insurance

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 can 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: _____

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: _____

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

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 the patient portal.

HIPAA guidelines do not allow us to leave a detailed phone message, email or text message of your medical findings, labs, or other medically sensitive information. We will make three attempts over three days to contact you directly by your cell phone number and will leave a call-back number. Non-critical information will stay on file in your patient records for your review at any time.

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

***Current Medications**: **(Include Dosage)**

1. 5.
2. 6.
3. 7.
4. 8.

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

SURGERIES: _____

_____

***MEDICAL HISTORY:** (Please circle *ALL* that apply to you)

- ○ **HIGH BLOOD PRESSURE**
- ○ **HIGH CHOLESTEROL**
- ○ **ARTHRITIS:** OSTEOARTHRITIS RHEUMATOID PSORIATIC
- ○ **BLOOD:** ANEMIA CLOTTING DISORDER PLATELET DISORDER LEUKEMIA LYMPHOMA
- ○ **CANCER:** SKIN LUNG COLON PROSTATE UTERUS CERVICAL BREAST
- ○ **DIABETES:** INSULIN DEPENDENT NEUROPATHY VISION ISSUES KIDNEY ISSUES
- ○ **ENT:** *(EARS/NOSE/THROAT)* EAR ACHES RUNNY NOSE SEASONAL ALLERGIES SINUS INFECTIONS CHRONIC COUGH SLEEP APNEA
- ○ **GASTROINTESTINAL:** COLITIS DIVERTICULITIS IRRITABLE BOWEL COLON POLYP CROHN'S DISEASE
- ○ **GI:** REFLUX ULCER BLEEDING
- ○ **MEN'S HEALTH:** PROSTATITIS VARICOCELE INCONTINENCE INFECTION
- ○ **WOMEN'S HEALTH:** ABNORMAL PERIODS PREGNANCY INFECTION
- ○ **HEART***:* HEART ATTACK ANGINA MURMUR ABNORMAL RHYTHM HEART FAILURE
- ○ **KIDNEY:** ABNORMALITY KIDNEY FAILURE DIALYSIS
- ○ **LUNG:** COPD ASTHMA CYSTIC FIBROSIS TUBERCULOSIS PNEUMONIA
- ○ **LIVER:** GALL STONES JAUNDICE CIRRHOSIS HEPATITIS
- ○ **MUSCULOSKELETAL:** INJURY GOUT LUPUS OSTEOPOROSIS BACK PAIN NECK PAIN JOINT PAIN
- ○ **PSYCHIATRIC / BEHAVIORAL NEUROLOGIC:** ANXIETY DEPRESSION ADHD SEIZURES HEADACHES MIGRAINES STROKE BIPOLAR
- ○ **SKIN:** ACNE ECZEMA CONTACT DERMATITIS PSORIAIS TINEA
- ○ **THYROID:** HYPO-THYROID HYPER-THYROID NODULE GOIDER

Other (Please Specify): _____

◯ **NO MEDICAL HISTORY**

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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