

Welcome  
to our  
Office!



906 Hwy 278 E.  
Amory, MS 38821  
Ph. 5612-256-662  
Fax 5264-256-662  
www.AmoryUrgentCare.com

Dear Patient:

Thank you for your interest in Amory Urgent Care. It is our primary goal to provide a high-quality, cost-effective alternative to traditional emergency room medicine and a time saving and after-hours alternative to your family doctor.

We ask that you be prepared to provide a **driver's license** and **insurance identification card** when you return to the check-in desk.

Patient Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M. Name + Suffix \_\_\_\_\_

Sex  M  F Date of Birth: \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Your Preferred Method of Contact  Email  Mobile Phone  Home Phone  Work Phone \_\_\_\_\_

Street Address / P.O. Box \_\_\_\_\_ Apt. / Lot # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Marital Status  S  M  D  WD

Email \_\_\_\_\_  No Email

Language \_\_\_\_\_ Race \_\_\_\_\_ Ethnicity \_\_\_\_\_

Place of Employment \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about us?  Brochure  Pharmacy  Mail  Friend/Family  Sign  Internet  Other \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION (Parent, if patient is a minor)**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M. Name + Suffix \_\_\_\_\_

Street Address / P.O. Box \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS # \_\_\_\_\_ Relationship \_\_\_\_\_

**PRIMARY INSURANCE**

Name of Ins. \_\_\_\_\_

Patient's Relationship to Policy Holder  Self  Spouse  Child  Other \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M. Name + Suffix \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Mobile \_\_\_\_\_ Email \_\_\_\_\_

**SECONDARY INSURANCE:**

Name of Ins. \_\_\_\_\_

Patient's Relationship to Policy Holder  Self  Spouse  Child  Other \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M. Name + Suffix \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS # \_\_\_\_\_ Phone # \_\_\_\_\_

Is this visit the result of an accident?  Yes  No

Did this accident occur at work?  Yes  No

I consent to treatment for myself or above minor child. I consent to receive automated reminders sent to my mobile phone Via call and/or text message. I understand that the examination and/or medical treatment I will receive is NOT intended to replace complete medical care by my personal primary care physician. I am aware that I will be responsible for co-payment or full payment at the time of services. Any pre-certification requirement that my insurance company requires is my responsibility to make. Furthermore, I allow Amory Urgent Care to release to my insurance company treatment and billing information, as requested, to process my claim. I allow Amory Urgent Care to accept assigned payments made by my insurance company on my behalf. I understand that by my lack of payment or if my insurance denies payment, I am responsible for payment in full for services rendered. I am aware that Amory Urgent Care does not accept Medicaid or file claims to Medicaid on my behalf. My failure to pay may result in collection proceedings. In addition, I authorize Amory Urgent Care to release to my primary care physician or specialty referral, any and all information related to my treatment at this clinic.

Patient Signature (if minor, signature of parent/guardian)

Date

### Authorization for Use or Disclosure of Protected Health Information

I authorize my physician and/or administrative and clinical staff of Amory Urgent Care, to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.

**Name, relationship and a personal identification method of persons you wish to allow access – for example:**

<b>Name:</b>	<b>Relationship:</b>	<b>Personal Identification:</b>
<b>John Doe</b>	<b>Father</b>	<b>Date of Birth, Address or last 4 of SS #</b>
_____	_____	_____
_____	_____	_____

Restriction Request: \_\_\_\_\_

This authorization to use and disclose this protected health information is being submitted by my request and shall be in force and effect until revoked in writing by me.

I understand that information used or disclosed pursuant to this authorization may be disclosed by Amory Urgent Care and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information to obtain payment from my health insurance company.

**I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.**

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Personal Representative

Date of Birth of Personal Representative \_\_\_\_\_ Last 4 of SS # \_\_\_\_\_

If not signed by the patient, please indicate relationship and describe authority to act:

Name of Patient: \_\_\_\_\_  parent or guardian of minor patient  
 guardian or conservator of an incompetent patient

### Financial Policy

The providers of this office are contracted with many of the local and national managed care plans. However, there are some plans that we do not currently have contracts with, including Medicaid. If you belong to a plan that we are not contracted with, our insurance/billing office will be glad to file a claim for you with the understanding that full payment is due at the time of service. Your claim will probably be applied to an out-of-network deductible or totally rejected.

It is important for you to understand that the patient is ultimately responsible for the fees that are not covered by the provider in this case. If you have any questions concerning the coverage your plan has with Amory Urgent Care, please call the patient relations department of your provider.

The responsible party will also be responsible for any durable medical equipment (splints, crutches, ace wraps, etc.) and medications not covered by the insurance plan or applied towards the deductible.

Thank you.

TRIAGE FORM



**FOR OFFICE USE ONLY**

Insurance: \_\_\_\_\_ Last Visit: \_\_\_\_\_  
 Date: \_\_\_\_\_ Account Number: \_\_\_\_\_ Room Number: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

How long: \_\_\_\_\_ Level of pain: \_\_\_\_ /10

School/Work Excuse Needed? Yes No

Birth Control: Yes No If Yes, What Type: \_\_\_\_\_

Allergies:

\_\_\_\_\_  
\_\_\_\_\_

Medications:

\_\_\_\_\_  
\_\_\_\_\_

Preferred Pharmacy Name: \_\_\_\_\_

Past Medical/Surgical History:

\_\_\_\_\_  
\_\_\_\_\_

Drink  Drug Use \_\_\_\_\_ Years Smoked \_\_\_\_\_ Years Smokless Tobacco  Passive Smoke Exposure

Occupation: \_\_\_\_\_ Primary Care Physician Name: \_\_\_\_\_

Married \_\_\_\_\_ Single \_\_\_\_\_ Widow/Widower \_\_\_\_\_ Divorced \_\_\_\_\_

Do you have any additional questions for your provider today?

\_\_\_\_\_  
\_\_\_\_\_

**FOR OFFICE USE ONLY**

Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ lbs/kg

Vital Signs: B/P \_\_\_\_\_ Pulse: \_\_\_\_\_ Resp: \_\_\_\_\_ Temp: \_\_\_\_\_ Pulse Ox: \_\_\_\_\_ LMP: \_\_\_\_\_