Insurance ____Yes ____ No PT ID #_____ Date: _____

NOTIFY THE RECEPTIONIST IMMEDIATELY IF YOU FEEL YOU HAVE A POTENTIALLY LIFE THREATENING SYMPTOM OR INJURY

Section 1. General Information – NOTE: STUDENTS – PLEASE ONLY INCLUDE PERMANENT ADDRESS BELOW

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

Gender: ____**Male** ____**Female** **Date of Birth:** _____

Social Security Number: _____

Street Address: _____

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

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Preferred Method of Contact (circle one): home cell work**

E-Mail: _____ **Emergency Contact:** _____ **Primary Care Physician:** _____

PCP Phone: _____

Emergency Contact Phone: _____ **PCP Fax:** _____

Section 2. Insurance Information (Primary Card Holder Information) – Add Secondary Insurance in Section 7

If same as above check this box and go to section 3 **Relationship to Patient:** _____

Insurance Card Holder: _____
Last Name *First Name* *M.I.*

Insured's Address: _____
Street Address *City* *State* *Zip*

Insured's Social Security Number: _____ **Insured's Phone:** _____

Insured's Date of Birth: _____ **Insured's Employer:** _____

Section 3. Reason for Visit & Co Pay Information

Reason for Visit: _____ **Insurance Co-pay Amount: $** _____

A: Is this visit work related: ____ **Yes** ____**No** ***If you answered YES to A, please fill out the back of this page***

B: Is this visit Auto Accident Related*: _____**Yes** ____**No** ***If you selected YES to B, please see Receptionist***

C: Is this visit related to another accident*: ____ **Yes** ____**No**

***If you answered yes to C, please answer the following*: Accident State:** _____ **Accident Date:** _____

Section 4. Guarantor* Information - This section only needs to be filled out if the patient is a minor or dependent

*The Guarantor is the adult who presents for treatment. In the case of a minor it is the adult that accompanies the patient for treatment or who signed the Authorization to Treat Minor Form

Guarantor's Gender: _____**Male** _____**Female**

Guarantor*: _____
Last Name *First Name* *M.I.*

Guarantor's Social Security Number: _____ **Guarantor's Date of Birth:** _____

Guarantor's Address: _____

Street Address *City* *State* *Zip*

Guarantor's Phone: _____ **Relationship to Patient:** _____

Section 5. How did you hear about us?

_____Billboard _____Bench Ad _____Event _____Insurance _____Work

_____Drive By _____Friend/Relative _____Doctor _____Living Social _____School

_____Internet Search _____Google Ad/Offer _____Groupon _____Newspaper _____Shopping Cart

Section 6. Insured's or Guarantor's Employer Information

Employer Name: _____

Contact Name: _____ **Contact Department:** _____

Street Address: _____

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

Employer Phone: _____ **Extension:** _____

Employer Fax: _____

If Injury, Date of Injury: _____

Claim Number (if applicable): _____

Section 7. Secondary Insurance Information (Primary Card Holder Information)

☐

If same as patient name check this box and do not complete this section

Relationship to Patient: _____

Insurance Card Holder: _____

Last Name *First Name* *M.I.*

Insured's Address: _____

Insured's Social Security Number: _____ **Insured's Phone:** _____

Insured's Date of Birth: _____

Thank you for choosing TRINITY URGENT CARE; it is our pleasure to serve you

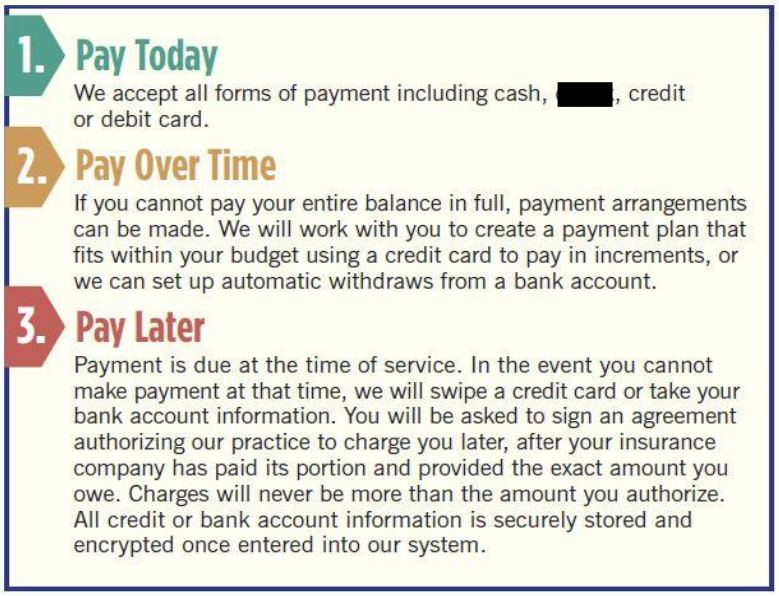
ALSHIFA MEDICAL GROUP PAYMENT POLICY

Please note that payment is due at the time of service.

We have a new payment policy in an effort to keep the cost of care as low as possible for our patients and to provide the highest quality of care at the lowest possible price.

Prior to any service, we will attempt to provide you with information about the estimated charges of your health services for this practice. This usually includes a co-payment, and any unmet deductible or coinsurance, which are to be paid **at the time of service**.

CASH PAY PATIENTS: **$100 Payment for the visit will be expected while you are in the office**, but if you receive other services such as: x-rays, labs, etc., and cannot pay your entire balance in full, payment arrangements can be made. We offer several convenient payment options. We can offer you the ability to leave a payment method on file with us, or the ability for us to accept preauthorized and automated payments from any of your credit cards, or debit cards. A refund will not be issued once you are seen by the provider.



We accept cash, debit or credit card for payment.

This policy is offered in an attempt to minimize misunderstandings about fees and your payment responsibility and helps our office keep the costs for our services down. Once you are seen by the provider, a refund will not be issued of copayments, coinsurance, deductible, etc. as those fees are due per your insurance policy.

Your cooperation is greatly appreciated.

SIGNATURE: _____DATE:_____

Alshifa Medical Group

Important Information for our Insurance Patients

Staff: Retain original for patient file; provide copy to patient upon request.

Payment is required for each visit including follow-up and re-checks.

Since you are using your insurance, we believe that it is important to communicate some important information regarding the financial obligations of your visit today. To make your visit more convenient, **we will attempt to obtain an estimate of your insurance benefits** from your insurance carrier at the time of service in order to determine your payment today. Since today's benefits are a "quote" we will collect and file to your insurance accordingly and then wait for the insurance company to process your claim. Your insurance will then determine if you are eligible for reimbursement or if you have any further responsibility and we will then collect any balance due as indicated on your insurance company's Explanation of Benefits (EOB). We will both receive this EOB in the mail—if any 'patient responsibility' amounts are indicated, **we will bill you** for these additional amounts. We will also write-off the entire discount that your insurance company indicates.

If we are unable to obtain an estimate of your insurance benefits you may be required to pay more than your co-pay. If you have a deductible type plan you may be required to pay in full. Deductibles vary and depend on your specific plan type. Insurance doesn't pay anything until your deductible is met. You may be eligible for a refund because your deductible was met and the 'patient responsibility' indicated on the EOB was less than the amount you paid. We will promptly refund you if this occurs. If the insurance EOB indicates you owe more, we will bill you for these services and by signing below you agree to pay for these services when you receive our statement.

Today, we will collect the copay/deductible/coinsurance as directed by your insurance company or as determined based on your ID card and insurance plan type. You may owe more after your claim is processed and the EOB is received. Sometimes copays don't cover certain services such as laboratory test, strep screens, immunizations, x-rays, injectable medicines/antibiotics, orthopedic supplies, surgical procedures and other services. It depends on your specific plan type. If the insurance EOB indicates you owe more, we will bill you for these services and by signing below you agree to pay for these services when you receive your statement.

I have read and been given a copy of this letter and understand that I may owe *Alshifa Medical Group* more than what I have paid today. Upon receipt of my insurance company's Explanation of Benefits (EOB), *Alshifa Medical Group* will bill me for any additional amounts indicated and I agree to pay these amounts upon receipt of the statement:

_____

Name (Printed)

_____ _____

Signature **Date**

HIPAA and Privacy Policy of Alshifa Urgent Care Clinics

Calvine Urgent Care, Sacramento and Trinity Urgent Care, Stockton

Use and Disclosure of Protected Health Information. In order to effectively provide care, there are times when we will need to share your personal health information with others beyond the urgent care practice for:
Treatment. With your permission we may use or disclose personal health information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside of the urgent care practice that we are consulting with or
Payment. Information will be used to obtain payment for the treatment and services provided. This will include contacting your health insurance company for prior approval of planned treatment or for billing purposes.
Operations. We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, and training staff.
Information Disclosed Without Your Consent. Under state and federal law, information about you may be disclosed without your consent in the following circumstances:
Emergencies. Sufficient information may be shared to address the immediate emergency you are facing.
Follow Up Appointments/Care. We will be contacting you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
As Required by Law. This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.
Governmental Requirements. We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations inspections and licensure. There also might be a need to share information with the Food and Drug Administration related to adverse events or product defects. We are also required to share information, if requested with the Department of Health and Human Services to determine our compliance with federal laws related to health care.
Criminal Activity or Danger to Others. If a crime is committed on our premises or against our personnel we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement and to warn any potential victims when we believe an immediate danger may exist to someone, or if we believe you present a danger to yourself.

PATIENT RIGHTS AND RESPONSIBILITIES You have the following rights under state and federal law:
Copy of Record. You are entitled to inspect the personal health record we have generated about you. We may charge you a reasonable fee for copying and mailing your record.
Release of Records. You may consent in writing to release of your records to others, for any purpose you choose. This could include your attorney, employer, or others who you wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization.
Restriction on Record. You may ask us not to use or disclose part of the personal health information. This request must be in writing. We are not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information.
Contacting You. You may request that we send information to another address or by alternative means. We will honor such request as long as it is reasonable and we are assured it is correct. We have a right to verify that the payment information you are providing is correct.
Amending Record. If you believe that something in your record is incorrect or incomplete, you may request we amend it. Your request should be made in writing. In certain cases, we may deny your request. If we deny your request for an amendment you have a right to file a statement you disagree with us. We will then file our response and your statement and our response will be added to your record.
Accounting for Disclosures. You may request a listing of any disclosures we have made related to your personal health information, except for information we used for treatment, payment, or health care operations purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. We will notify you of the cost involved in preparing this list.
Questions and Complaints. If you have any questions, or wish a copy of this policy or have any complaints you may contact us in writing for further Information. You also may complain to the Secretary of Health and Human Services if you believe this practice has violated your privacy rights. We will not retaliate against you for filing a complaint.
Changes in Policy. This practice reserves the right to change its Privacy Policy based on the needs of the practice and changes in state and federal law.

Read all sections before signing.

IMPORTANT: I acknowledge that I have received and read this privacy notice.

Patient Name_____

Signature_____Date_____

We respect patient confidentiality and only release personal health information about you in accordance with the State and federal law. This notice describes our policies related to the use of the records of your care and how you may get access to this information. Please review.

RELEASE OF INFORMATION

I agree that Alshifa Medical Group may disclose any portion of my/the patient's medical record/s including but not limited to, information about my/the patient's diagnosis and/or treatment, received at Trinity Urgent Care or Calvine Urgent Care, to any person, regulatory or governmental agency, or corporation including, but not limited to insurance companies or health care service plans which are, or may be liable for, all or any portion of Alshifa's charges, to the extent necessary to determine liability for payment and to obtain reimbursement, or as otherwise permitted or required by law. To ensure coordination of my/the patients' ongoing care and treatment, I also release any or all medical information to my/the patient's primary care physician or health care provider and any consulting physicians or health care providers participating in my/the patient's care.

_____Initial

CONSENT FOR TREATMENT

I consent to the performance of all routine medical care and treatment (including lab tests, xrays and/or medical procedures, etc) which may be performed and deemed medically necessary by and under the general and specific instruction of the physician and/or authorized health care providers of Alshifa Medical Group.

_____Initial

PRIVACY NOTICE: HIPPA

By initialing this section you acknowledge that you received and read the Notice of Privacy (HIPPA) of Alshifa Medical Group outlining the use or disclosure of your protected health information.

_____Initial

FINANCIAL POLICY

By initialing this section you acknowledge that you received and read the Financial Policy of Alshifa Medical Group and have been offered three (3) options for payment for today's visit. The office policy is that if no payment arrangements have been made at the time of service we must have a payment method on file. We reserve the right to charge any balance over 90 days.

_____Initial

AUTHORIZATION

I certify that I have read the information above and have been given the opportunity to have any questions answered fully to my satisfaction. I have been given the option to receive a copy of this agreement upon request. I further certify that I am 1) the patient or 2) the patient's legal representative or 3) is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Print Patient's Name: _____

_____ _____

Signature of Responsible Person if Patient is a Minor Date