LIMITS OF LIABILITY-URGENT CARE CENTERS, PATIENT OPTIONS AND GENERAL CONSENT TO TREATMENT

LIMITATION OF OUR CARE: I am hereby informed that the Upper Valley Urgent Care Center, P.A. treats MINOR MEDICAL problems which are conditions considered stable enough that the patient need only be seen sometime within the next twenty-four hours by a healthcare provider. The Upper Valley Urgent Care Center is not staffed or equipped to handle EMERGENCY medical conditions, which are those conditions requiring immediate attention. I understand that the local hospital emergency department is where such problems should be evaluated. I also understand that UVUCC is not my primary physician and that the full scope of this visit and my overall health are the responsibility of my primary doctor.

PATIENT OPTIONS FOR CARE: I recognize that my care on this date could have included my own personal physician, and of several local hospital emergency departments or urgent care centers, and other specialty hospitals or specialist physicians, all of which are other options for my care.

GENERAL CONSENT TO TREATMENT: Understanding the limitations of Medical Care Provided at an urgent care center and my available options; I give permission to the Upper Valley Urgent Care Center, P.A. to perform the medical and surgical processes, treatment, and/or procedure that the physician and/or other non-physician providers and assistants may deem to be necessary.

Further, I understand and accept that there are risks of mishaps and possible adverse outcomes associated with receiving medical care anytime including but not limited to: reactions to medication, loss of life or limb under the worst circumstances, extending fractures during straightening procedures, or during surgical procedures attendant bleeding, damage to blood vessels, nerves, or tendons as well as ever present risks of infections

ADVICE TO FURTHER CARE: Finally, I understand that my diagnosis and management due to the limitation of resources and personnel, should be considered tentative and that if evaluation promptly at the nearest local hospital emergency department.

BASIC LABS AND STUDIES TO BE COMPLETED PRIOR TO PROVIDER VISIT: Our goal is to provide you fast, friendly, quality medical care. In order to do this competently, we need to obtain some basic labs and begin some studies just as soon as you get here. The results of these tests will help us narrow down your diagnosis quickly and help our provider expedite your visit in order to provide the highest quality service. Depending upon many factors, some of the following may be obtained.

- **Diabetes Screen: Glucose / Urinalysis**
- **Respiratory Symptoms: Influenza/ Strep / RSV (age 3 and under)**
- **Fatigue Symptoms: Glucose/ Influenza/ Hemoglobin/ Thyroid/ Urine**
- **Abdominal – Pelvic Pain Females: Urine/ Pregnancy**
- **Any Injuries or Pain: X-Ray of injury**
- **EKG and Chest X-ray: Chest Pain, Upper Back Pain, Shoulder Pains, Shortness of Breath; Abdominal Pain, Dizziness, Lightheadedness, Nausea and Vomiting,**
- **Lower Back or Pain: Urinalysis/ Pregnancy, X-ray of the Low Back**

_____ ACCEPT _____ DECLINED
Initials Initials

HEALTHCARE PROVIDER: I also understand that my care today may be provided by either/and/or a physician or midlevel practitioner such as a Physician's Assistant (PA) or Nurse Practitioner (NP).

_____
Signature and Date

PATIENT RECORD OF DISCLOSURE

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and request PHI to the minimum necessary to accomplish the intended purposes. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

NOTE: Uses and disclosure for, Treatment Records, Payment Information and Healthcare Operations may be permitted without prior consent in an emergency.

In general, the HIPPA 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, communication or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

IMPORTANT! How can we get a hold of you?

We will contact you using all the phone numbers provided in your registration form.

_____ O.K. to leave message with detailed information

_____ Leave message with call-back number only

NOTE: Bills and statements are sent to home addresses

I AUTHORIZE YOU TO DISCUSS MY MEDICAL HISTORY AND RELEASE ANY AND ALL MEDICAL INFORMATION TO THE FOLLOWING INDIVIDUALS: (Fill in all that apply)

Name: _____ Phone: _____

Name: _____ Phone: _____

_____ **Do not discuss my medical history and release any and all medical information other than myself.**

PRIVACY PRACTICES ACKNOWLEDGEMENT (HIPPA INFORMATION SHEET)

I have received the Notice of Privacy Practice HIPPA information sheet and I have been provided an opportunity to review it.

Signature: _____ Date: _____

CELL PHONE USE

Cell phone operations during the medical exam by the patient, family members, friend or other including making or receiving calls, phones ringing or vibration, or patients writing or reading text messages; all disrupt and detract from our effort to provide you prompt, quality medical care. We are requesting that for these few brief minutes your phone be completely SHUT-OFF. We appreciate your cooperation and apologize for any inconvenience.
Further, I agree NOT to contact or otherwise communicate with other physicians while here without first coordinating with the provider on duty. In addition per our company policy no filming of any medical procedure will be allowed.

Name: _____ Birthdate: _____

Signature: _____ Date: _____

Date _____

Email Address _____ **(PLEASE PRINT)** Home Phone _____

Patient Information

Name _____ SS # _____
Last Name First Name Middle Initial

Address _____ Cell Phone _____

City _____ State _____ Zip Code _____

Sex ☐ M ☐ F Age _____ Birthdate _____

Marital Status ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partner for __ years

Patient Employer/ School _____ Occupation _____

How did you hear about us? _____

In case of emergency who should be notified? _____ Phone _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ SS # _____

Address (If different from patient's) _____ Phone _____

City _____ State _____ Zip Code _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ SS # _____

Address (If different from patient's) _____ Phone _____

City _____ State _____ Zip Code _____

Assignment, Release and Financial Responsibility

I certify the above information is true and accurate. I authorize the release of any medical or other information necessary to process a claim or continue medical treatment. I also authorize payment of medical benefits paid directly to Upper Valley Urgent Care Center. I acknowledge that payment and/or co-payment is due at the time of service or treatment. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of minors and/or children. I understand that by UVUCC filing a claim with my insurance company, I am not relieved from responsibility for the payment of services; and after **60 days** from oldest date of service, I will be billed for any unpaid services. *I understand that I will be responsible for resolving any further disputes with my insurance company.*

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Open Daily 8am to 9pm

www.uvucc.com

Upper Valley Urgent Care Center, P.A.

Registration Form