afc Doctors Express®
URGENT CARE

Patient Registration Form

Please fill out form completely. See the back page of this form for Notice of Privacy Practices.

Patient's Full Name: _____ Social Security #: _____

Date of Birth: _____ Sex: ❑ M ❑ F Marital Status: ❑ Child ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Street Address /Apt #: _____ Patient's Employer: _____

City, State, Zip: _____ Work Phone: _____

Home Phone: _____ ❑ *Okay to leave message?* Emergency Contact: _____

Local or Cell Phone: _____ ❑ *Okay to leave message?* Emergency Contact Phone: _____

Confidential Email Address: _____ Relationship to Patient: _____

Primary Care Physician: _____ ***Was this a work related injury?*** ❑ Yes ❑ No

Primary Care Phone or City & State: _____ ***Was this the result of a motor vehicle accident?*** ❑ Yes ❑ No

How did you hear about us? _____ **REASON FOR VISIT:** _____

Based on government regulations we are required to ask the following information: ❑ *I prefer not to answer*

Preferred Language: _____ Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Caucasian ❑ Native Hawaiian or Other Pacific Islander

Ethnicity: ❑ Hispanic or Latino ❑ Non Hispanic or Latino

GUARANTOR INFORMATION

❑ *Check if same as patient information and sign at X below. If not, please complete entire section and sign.*

Name: _____ Sex: ❑ M ❑ F Relationship to Patient: ❑ Spouse ❑ Child ❑ Other

Date of Birth: _____ SSN#: _____ Guarantor Employer: _____

Street Address /Apt #: _____ Employer Phone: _____ Ext #: _____

City, State, Zip: _____

Home Phone: _____

Local or Cell Phone: _____ Email: _____

I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office is due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefits to this office. In the event that my account is turned over to a collection agency, I agree to pay all late fees, costs of collection fees, and/or attorney's fees and all court costs, if any.

X: _____ **DATE:** _____

Patient/Guarantor Signature

INSURANCE INFORMATION

Primary Insurance

Insurance Plan Name: _____ Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Policy ID: _____ Group Number: _____ Subscriber Name: _____

Subscriber Date of Birth: _____

Secondary Insurance *(if applicable)*

Insurance Plan Name: _____ Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Policy ID: _____ Group Number: _____ Subscriber Name: _____

Subscriber Date of Birth: _____

AUTHORIZATION *(Optional)*

By providing this authorization to release my Personal Heath Information (PHI) to the following individual(s), I understand that the authorization is voluntary and is being done at the request of the patient. I understand that I may refuse to sign this authorization and my treatment and/or payment obligations will not be affected. I understand that the health information to be obtained and released may be subject to re-disclosure by the recipient of the health information and no longer protected by the federal Privacy Rules. I understand that I may revoke this authorization at any time by notifying AFC-Doctors Express in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation. I understand that this authorization is for six (6) years until specified otherwise.

I herby authorize AFC-Doctors Express to use and disclose health information to the following:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

CONSENT FOR TREATMENT *I, the undersigned, consent to the care and treatment by the attending physician, his/her associates or assistants. I acknowledge that no guarantees have been made as to the effect of such treatment.*

SIGNED: _____ **DATE:** _____

Patient Signature (if patient over age of 13)

Updated 8-15-13

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***PLEASE REVIEW IT CAREFULLY.***

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). We must follow the privacy practices that are described in this Notice (which may be amended from time to time). For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

A. Your PHI may be used and disclosed by the physician, our office staff and others outside of our offices that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the business, and any other use required by law. We may use and disclose PHI without your written authorization for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

1. Treatment: We may use and disclose PHI in order to provide treatment to you. For example, we may use PHI including your medication history to diagnose, treat, and provide medical services to you. In addition, we may disclose PHI to other health care providers involved in your treatment.

2. Payment: Under federal law we may use or disclose PHI so that services you receive are appropriately billed to, and payment is collected from, your health plan. By way of example, we may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services. Under Washington state law, release of PHI to health plans require an authorization provided by you to us or to your health plan. We may contact the Guarantor for your visit in order to obtain payment.

3. Health Care Operations: We may use or disclose your PHI in order to support our business activities. These activities include, but are not limited to business associates, quality assessment activities, internal investigations, performance reviews, and training employees. In addition, we will use a sign-in sheet at the registration desk where you will be asked to provide your name and date of birth. We may also call you by name in the waiting room when the physician is ready to see you. We may use or disclose your PHI to contact you to remind you of an appointment, to notify you of test results, to inform you of health-related services that may be of interest to you, and to check on your treatment, progress, and satisfaction with our services.

4. Required or Permitted by Law: As required by Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity, National Security, Worker's Compensation, Inmates, and other Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services.

B. Permissible Uses and Disclosures That May Be Made Without Your Authorization, But For Which You Have An Opportunity to Object.

1. Family and Other Persons Involved in Your Care. We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

2. Disaster Relief Efforts. We may use or disclose protected health information to a public or private entity authorized by law or its charter to assist in disaster relief efforts for the purpose of coordinating notification of family members of your location, general condition, or death.

C. Other permitted and required uses and disclosures: Use or Disclose of your PHI for marketing or sale of your PHI to third parties, will be made only with your authorization. Once given, you may withdraw authorization at any time in writing.

II. YOUR INDIVIDUAL RIGHTS

A. Right to Inspect and Copy. You may request access to your medical records and billing records maintained by us in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny access to your records. Under federal law, you may not inspect or copy psychotherapy notes, information compiled in anticipation of, or use in, a legal proceeding, and PHI that is otherwise prohibited. We may charge a fee for the costs of copying and sending you any records requested.

B. Right to Alternative Communications. You may request, and we will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

C. Right to Request Restrictions. You may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. If you have paid for your services in full and ask us not to disclose your visit to your insurance company, we will honor that request. We are not required to agree to any other restriction that you may request.

D. Right to Accounting of Disclosures. Upon written request, you may obtain an accounting of certain disclosures of PHI made by us in the last six years. This right applies to disclosures for purposes other than treatment, payment or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations. We are required by law to notify you if your unsecured PHI is breached.

E. Right to Request Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we deny your written request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

F. Right to Obtain Notice. You have the right to obtain a paper copy of this Notice by submitting a request to the center's Compliance Officer at any time.

G. Questions and Complaints. If you desire further information about your privacy rights, or are concerned that we have violated your privacy rights, you may contact the center's Compliance Officer. You may also file a written complaint with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint with the Director or with our office.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date. This Notice is effective on August 15, 2013.

B. Changes to this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice in the waiting area of our office and on our web site. You may also obtain any revised notice by contacting the center's Compliance Officer.

I have reviewed the AFC-Doctors Express Notice of Privacy Practices and understand that I may request a copy of the policy at any time.

SIGNED: _____ **DATE:** _____