EXPRESS CLINIC

How did you hear about us?
Web Word of Mouth Drive By AD Mailer

PATIENT INFORMATION

Date of Birth _____/_____/_____ Address _____

Last Name _____ Apt _____ Home Phone ( )_____-_____

First Name _____ City _____ Cell Phone ( )_____-_____

Middle Initial _____ State _____Zip _____ Preferred ☐Home ☐Mobile/Work

Social Security #_____-_____-_____ Email _____

Sex ☐M ☐F

Emergency Contact Name_____Phone_____Relation _____

Patient Employed By_____Work Phone_____

PARENT/GUARANTOR INFORMATION

Name (Last, First, Middle) _____

Date of Birth_____/_____/_____Social Security #_____Sex ☐M ☐F

Address_____City_____State_____Zip_____

Home Phone_____Mobile/Work Phone_____Preferred ☐Home ☐Mobile/Work

Relationship to Patient ☐Parent ☐Guardian ☐Spouse

PRIMARY INSURANCE

Carrier _____ Policy Holder Name _____

Member ID_____Group # _____ Date of Birth_____/_____/_____Sex ☐M ☐F

Insurance Claims Address _____ Address _____

Phone _____ Relationship to Patient: ☐Parent ☐Guardian ☐Spouse

SECONDARY INSURANCE

Carrier_____ Policy Holder Name _____

Member ID_____Group # _____ Date of Birth_____/_____/_____Sex ☐M ☐F

Insurance Claims Address _____ Address_____

Phone _____ Relationship to Patient ☐Parent ☐Guardian ☐Spouse

AUTHORIZATION AND RELEASE

Authorization of Treatment: By signing this consent form, I voluntarily consent to the administration and cost of medical and surgical procedures, x-ray(s) and medication(s) for myself and my dependents.

_____Initial: I understand AMHCT, LLC is a Free Standing Urgent Care Facility, and is billed as an Urgent Care visit to my insurance carrier.

Guarantee of Payment:

____Initial: SELF PAY: I elect to pay for all services rendered in full today. I understand that my insurance will NOT be billed by AMHCT, LLC .

____Initial: Assignment of Insurance Benefits: By signing this consent form, I authorize payment directly to AMHCT, LLC for all benefits other- wise payable to me. I also acknowledge that AMHCT will submit my bill to my insurance carrier as a courtesy; however, I am ultimately responsible for all charges incurred, unless both parties mutually agree otherwise. I agree that I will pay my estimated balance based on the best available information of my current policy. I understand this is only an estimate. While amhct makes every effort to verify my correct insurance information prior to leaving, I understand amhct cannot guarantee the accuracy of my bill until it has been fully processed by my insurance carrier.

Patient/Responsible Party Signature_____Date _____

Advanced Medical
EXPRESS CLINIC

Initial Visit Form

ADDITIONAL INFORMATION (PLEASE FILL IN COMPLETELY, ALL INFORMATION REQUIRED)

Patient's Name: _____

Marital Status: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

Ethnicity: ☐ HISPANIC/LATINO ☐ NON-HISPANIC RACE: _____ PREF. LANGUAGE: _____

REASON FOR VISIT: _____ DATE: _____

WHO IS YOUR (PCP) PRIMARY CARE PHYSICIAN? _____

WHEN WAS YOUR LAST VISIT TO YOUR PCP? LESS THAN 6 MONTHS MORE THAN 6 MONTHS MORE THAN 1 YEAR PHARMACY

CURRENT MEDICATIONS:

DRUG: _____ DOSAGE: _____ FREQUENCY: _____

DRUG: _____ DOSAGE: _____ FREQUENCY: _____

DRUG: _____ DOSAGE: _____ FREQUENCY: _____

DRUG: _____ DOSAGE: _____ FREQUENCY: _____

DRUG: _____ DOSAGE: _____ FREQUENCY: _____

MEDICATION ALLERGIES: _____ OTHER ALLERGIES: _____

PHARMACY: _____

HISTORY

Medical History _____

Surgical History _____

Family History _____

Social History: Substance abuse: Y/N Smoker: Y/N Packs per day? Alcohol abuse: Y/N

.....Staff Use Only Below This Line.....

S

O

A

P

B/P_____/_____ P_____ R_____ 02_____% T_____ WT_____ HT_____

Advanced Medical
EXPRESS CLINIC

PRIVACY PRACTICES

Receipt of Privacy Practices: I acknowledge that a copy of the Notice of Privacy Practices of AMHCT, LLC is available to me upon request and can be downloaded at advancedmedicalhousecalls.net I understand that a copy of this consent form may be used with the same effectiveness as the original.

AUTHORIZATION OF RELEASE FORM

Release of Medical Records: By signing this form I authorize AMHCT, LLC to release verbally, electronically, and/or in writing confidential medical information for purposes of treatment, payment of charges, quality assurance and utilization review, transfer and follow-up procedures to my insurance carrier, employer (if treatment is related to employment), other healthcare provider (s), and the following person (s).

Name:_____ Name:_____

Relation:_____ Relation:_____

Phone: _____ Phone: _____

☐ I hereby authorize the release of my **COMPLETE** health record (including records relating to mental health care, communicable disease, HIV or AIDS, and treatment of alcohol/drug abuse).

OR

☐ I hereby authorize the release of my **COMPLETE** health record **WITH EXCEPTION** of the following information:

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Financial Account information
- ☐ Other (please specify):_____

OR

☐ I hereby authorize the release of following information:

- ☐ Records for dates of service from_____to _____
- ☐ Narrative reports ☐ Lab results ☐Hospital records ☐ Pathology results
- ☐ Radiology results

Patient Signature:_____Date: _____

ANCILLARY SERVICES

Our physician may recommend certain laboratory and/or radiology tests to help aid in the treatment and diagnosis of your condition. Some of these services are not routinely performed in our facility. For example, certain laboratory specimens are sent out to an independent lab for analysis. If this occurs, the lab will bill separately for their services. Should an X-Ray be performed in our facility, an independent radiologist will interpret these exams and report findings.

INITIAL _____

PATIENT RIGHTS

I acknowledge I have reviewed and received a copy of "Patient Rights and Responsibilities" from AMHCT, LLC .

Patient Signature:_____Date: _____