Instant Medical Care
I Care Clinic
I Care Healing & Wellness Center
3262 Vineland Road, Unit 102, Kissimmee, FL 34746, Phone: 407-397-8937, FAX: 407-397-9547

Patient Registration Form

Patient's Name: asd *Last* sad *First*

Patient's Address: sadas

City: _____ *State:* sa *Zip code:* _____

Home Phone: _____ *Alternate Phone:* _____

Date of Birth: _____ *Age:* _____ *Sex:* ☑ *Male* ☑ *Female*

Email Address:

REASON FOR TODAY'S VISIT: _____

IS THIS A WORK RELATED INJURY? ☐ *Yes* ☐ *No*

Employer: _____

WAS THIS CAUSED BY AN AUTO ACCIDENT? ☐ *Yes* ☐ *No*

How did you hear about I Care Clinic? _____

How will you be paying for today's visit? ☐ *Cash* ☐ *Debit* ☐ *Insurance* ☐ *Credit*

**If using insurance, please provide patient's Social Security Number:* _____-_____-_____

If using insurance and **patient is not the policy holder, please provide the policyholder's*

Name: _____ *SSN:* _____-_____-_____ *Date of Birth:* _____

Address: *City:* *State:* *Zip:*

***(Patient's who are being seen for <u>PAIN MANAGEMENT</u> will have to pay either cash or credit card)**

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Authorization to Treat

I, _____, hereby authorized the staff of I Care Clinic / Instant Medical Care / I Care Healing & Wellness Center to provide me with medical treatment. I agree to inform I Care Clinic / Instant Medical Care / I Care Healing & Wellness Center if I have any concerns about my medical treatment at the time of services are being rendered.

We/I _____, the parent(s) / guardian(s) of _____ give I Care Clinic / Instant Medical Care / I Care Healing & Wellness Center and its employees the right to treat my son / daughter or legal ward.

Release of Information

The medical records concerning patient care are the property of I Care Clinic and are maintained for the benefit of the patient, the medical staff and center. I hereby authorized I Care Clinic / Instant Medical Care / I Care Healing & Wellness to release information and copies of my medical records to physicians, any guarantor of payment on my account, insurance companies (and other third party payers, including workers' compensation carriers and the patient's employer) for which I have assigned benefits for my treatment or care. This includes authorization to release information pertaining to: psychiatric and/or psychological care, alcohol and- or substance abuse, serologic test results (including but not limited to Acquired Immune Deficiency Syndrome or positive HIV results.) I authorize the provider to use all available means of communication to transmit such information, including electronic mail or electronic fax transmissions.

Please Initial: _____

Medicare

All patients must check one box in the Medicare section. All patients that have Medicare Part B coverage must complete the MSP Questionnaire.
I confirm that I am ***not enrolled*** in Medicare Part B.

Please provide your Medicare card along with your primary insurance

I have Medicare Part B for primary insurance.
I have Medicare Part B as my secondary Insurance.

Please Initial: _____

Financial Policy

I Care Clinic / Instant Medical Care / I Care Healing & Wellness Center will be happy to accept your check as a form of payment. In the unlikely event that your check is returned unpaid, you understand and agree that we will electronically collect the maximum returned check processing charge allowable by state law. I Care Clinic / Instant Medical Care / I Care Healing & Wellness Center will discuss our fees with you at any time. All refunds of less than $10 will be held and applied to future visit unless you request the refund. In the unlikely event that your account is referred to a collection agency, you understand and agree that a service fee will be charged. All patients pay for services, in full, at the time that services are rendered.

Please Initial: _____

Assignments of Benefit

The undersigned, whether signing as a patient, representative or guarantor, hereby authorizes direct payment of any insurance benefits otherwise payable to or on behalf to me by virtue of my visit to I Care Clinic / Instant Medical Care / I Care Healing & Wellness Center. I hereby direct the insurer to pay such benefits directly to I Care Clinic / Instant Medical Care / I Care Healing & Wellness Center in consideration of the professional services rendered to me or my insured dependent or any insured person designated in my policy. I understand I will be responsible for payment of services not covered and/ or denied by health insurance.

Please Initial:

Radiology

I understand that if my treatment requires radiology procedures (X-ray), it is my responsibility to inform the medical staff if I am pregnant or think I may be pregnant.

Please Initial: _____

I understand that if symptoms persist I should seek additional medical care

Signature: _____ **Date:** _____

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HIPAA AUTHORIZATION TO USE AND DISCLOSE INDIVIDUAL HEALTH INFORMATION FOR RESEARCH PURPOSES

1. Purpose. As a research participant, I authorize I Care Clinic & Instant Medical Care and the researcher's staff to use and disclose my individual health information for the purpose of conducting the research project entitled I Care Clinic & Instant Medical Care Urgent Care

2. Individual Health Information to be Used or Disclosed. My individual health information that may be used or disclosed to conduct this research includes: demographic information, results of physical exams, blood tests, x-rays, and other diagnostic and medical procedures as well as medical history.

3. Parties Who May Disclose My Individual Health Information. The researcher and the researcher's staff may obtain my individual health information from:

Hospitals:
_____

Clinics:
_____

Other Providers:
_____

Health Plan:
_____,
and from hospitals, clinics, health care providers and health plans that provide my health care during the study.

4. Parties Who May Receive or Use My Individual Health Information. The individual health information disclosed by parties listed in item 3 and information disclosed by me during the course of the research may be received and used by I Care Clinic & Instant Medical Care and the researcher's staff.

5. Right to Refuse to Sign this Authorization. I do not have to sign this Authorization. If I decide not to sign the Authorization, I may not be allowed to participate in this study or receive any research related treatment that is provided through the study. However, my decision not to sign this authorization will not affect any other treatment, payment, or enrollment in health plans or eligibility for benefits.

6. Right to Revoke. I can change my mind and withdraw this authorization at any time by sending a written notice to I Care Clinic & Instant Medical Care to inform the researcher of my decision. If I withdraw this authorization, the researcher may only use and disclose the protected health information already collected for this research study. No further health information about me will be collected by or disclosed to the researcher for this study.

7. Potential for Re-disclosure. Once my health information is disclosed under this authorization, there is a potential that it will be re-disclosed outside this study and no longer covered by this authorization. However, the research team and the University's Institutional Review Board (the committee that reviews studies to be sure that the rights and safety of study participants are protected) are very careful to protect your privacy and limit the disclosure of identifying information about you.

7A. Also, there are other laws that may require my individual health information to be disclosed for public purposes. Examples include potential disclosures if required for mandated reporting of abuse or
neglect, judicial proceedings, health oversight activities and public health measures. 3262 Vineland Road, Unit 102 Kissimmee, FL 34746 Phone: 407-397-8937 FAX: 407-397-9547

8. Suspension of Access. I may not be allowed to review the information collected for this study, including information recorded in my medical record, until after the study is completed. When the study is over, I will have the right to access the information again.

This authorization does not have an expiration date.

I am the research participant or personal representative authorized to act on behalf of the participant.
I have read this information, and I will receive a copy of this authorization from after it is signed.

_____ _____
Signature of Patient Date

_____
Printed Named of Patient

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Health History

Date: _____

Patient Name: _____ Date of Birth: _____

ALLERGIES:

☑ Sulfa/Bactrim ☑ Penicillin/Amoxicillin ☐ Non-Steroidal Anti-Inflammatory/Asprin ☐ Cipro ☐ Azithromycin

☑ Other: _____

Current Medications:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medical Conditions:

- ☐ High Blood Pressure
- ☐ Bleeding Disorder
- ☐ Glaucoma
- ☐ Diabetes
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Sleep Apnea
- ☐ Asthma
- ☐ Cancer (of_____)
- ☐ Poor Circulation
- ☐ Heart Disease
- ☐ Other:_____

Family History:

	Mother	Father
☐ High Blood Pressure	☐	☐
☐ Bleeding Disorder	☐	☐
☐ Glaucoma	☐	☐
☐ Diabetes	☐	☐
☐ Stroke	☐	☐
☐ Thyroid Disease	☐	☐
☐ Sleep Apnea	☐	☐
☐ Asthma	☐	☐
☐ Cancer (of_____)	☐	☐
☐ Poor Circulation	☐	☐
☐ Heart Disease	☐	☐
☐ Other:_____	☐	☐

Past Surgeries:

_____

_____

_____

_____

How often do you use alcohol?

☐ Never ☐ Occasionally ☐ Daily

(_____

Do you smoke?

☐ Yes (_____) ☐ No ☐ Quit