

MedNOW
Walk-In Urgent Care Center
503 S. Aspen, Broken Arrow, OK 74012
Phone: 918-286-6331 Fax: 918-806-6330

PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

DATE OF BIRTH ___/___/___ SEX M OR F SSN _____ - _____ - _____ MARITAL STATUS M S W D

ADDRESS _____ APT# _____ CITY _____ STATE _____ ZIP _____

HOME# _____ WORK# _____ CELL# _____ EMPLOYER _____

REASON FOR VISIT _____ PRIMARY CARE PHYSICIAN _____

HOW DID YOU HEAR ABOUT US?(FRIENDS/FAMILY /DR'S OFFICE/ SIGN/ PHONE BOOK/INTERNET /INSURANCE CO).

MAY WE SEND YOU OUR NEWS LETTER AND COUPONS TO YOUR EMAIL ADDRESS ___ YES ___ NO EMAIL _____

IN CASE OF EMERGENCY _____ RELATIONSHIP _____ PHONE# _____

PRIMARY INSURANCE POLICY HOLDERS NAME _____ DOB ___/___/___

EMPLOYER _____ SSN _____ - _____ - _____

PLEASE GIVE ALL INSURANCE CARDS TO THE RECEPTIONIST (PRIMARY, SECONDARY or TERTIARY IF ANY) YOU MUST HAVE ALL CARDS.

GUARANTOR INFORMATION (PARENTS OR LEGAL GUARDIANS INFORMATION)

NAME _____ RELATIONSHIP TO PATIENT _____

SSN _____ - _____ - _____ DOB ___/___/___ PHONE # _____

EMPLOYER NAME _____ PHONE# _____

MedNOW can not release your records to anyone without your express permission. Please list anyone you would like to have access to your records.

Name: _____ Relationship _____

Name: _____ Relationship _____

NOTICE OF RIGHTS: Information in your medical record that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court of the Department of Health, disclosure among health care providers or disclosure for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the Department of health or by law

Signature of Patient or Legal Representative _____ Date _____

MedNOW
Walk-In Urgent Care Center
Dr. David Miller and Dr. Tony Hill
503 S. Aspen Broken Arrow, OK 74012
918-286-6331
Notice of Practice Protocol

This letter is designed to answer questions you may have regarding your medical care. Our medical staff, physicians, receptionists, secretaries and technical personnel operate as a team. We take great pride in our training, knowledge, and capabilities, and we want you to know that we are dedicated to giving you quality health care.

CLINIC HOURS Regular Clinic hours are from 8am to 8pm, Monday through Friday, and 9am to 4pm Saturday and Sunday.

TELEPHONE CALLS Our telephones are answered during normal clinic hours. Our staff has been instructed to handle all incoming calls. This allows the doctors to attend to their scheduled patients with a minimum of interruptions. If you have questions that the staff cannot answer, the physician or nurse will return your call at the earliest possible time..

PRESCRIPTIONS & REFILLS Just as we cannot treat illnesses over the phone, we cannot prescribe medications over the phone. Medications will be handled only during regular business hours. Refill requests can be handled through your pharmacy. Please allow 24 hour for us to get back with them.

FEES & PAYMENTS We make every effort to keep your medical costs to a minimum. **You can help by paying at the time of your visit.** For your convenience, we accept cash, check, Mastercard and VISA.

INSURANCE If you have insurance coverage, please understand that this is an agreement between **you** and **your** insurance company. **You are responsible for the payment of your bill regardless of the status of your insurance claim.** We will be happy to submit your insurance for prompt reimbursement to you. Our physicians are participating in the Medicare program. This means that they will accept what Medicare approves, **not what Medicare pays.** Medicare will pay 80% of approved charges and the patient is responsible for the 20% due. This is expected at the time services are rendered. HMO's & PPO's will be filed by our office according to our contract with that individual carrier. All co-payments are to be paid by the patient at the time of services. Please notify us **BEFORE** seeing the doctor that you are a member of an HMO or PPO so that we may obtain proper authorization for those services. Any patient seen without proper authorization will be expected to pay for services at the time of visit.

THANK YOU FOR ALLOWING US TO SERVE YOU

Signature: _____ Date: _____

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Medical Record#: _____

Patient Birthdate: _____ SSN #: _____

I hereby authorize MedNOW Urgent Care to: _____ use or disclose or _____ obtain

Protected Health Information described below:

NAME OF INDIVIDUAL OR INSTITUTION:

MedNOW Urgent Care

503 S ASPEN AVE, BROKEN ARROW, OK 74012

Information authorized for use or disclosure, or to be obtained:

_____ All medical information concerning this patient

_____ Medical Information of this patient compiled between _____ to _____

_____ Only: _____ Dates of Treatment, If known: _____

The information will be obtained, used, or disclosed for the following purpose(s) only:

_____ Insurance _____ Continued treatment _____ Legal _____ At the request of the patient or patient's representative

_____ Other(Specify) _____

I understand:

* I may revoke this authorization at any time, **in writing**, except revocation will not apply to information already detained, used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Rights. Unless revoked, the automatic expiration date will be one (1) year from date of signature or upon occurrence of the following event.

. * I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information. The entity authorized to disclose the information will not be compensated by the recipient.

* Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

* I have the right to inspect the health information to be released and I may refuse to sign this authorization.

* Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing this authorization

Signature of Patient or Legal Representative _____ Date _____

Written Acknowledgment Form: I have received a copy of MedNOW Urgent Care Center's Notice of Privacy Practices.

Signature of Patient or Legal Representative _____ Date _____

PATIENT MEDICAL HISTORY

Name: _____ Date Of Birth: _____

Reason for today's visit: _____

Current Medications: _____

Medication Allergies: _____

Chronic/Inactive Medical Conditions: __None

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Neuro: Stroke, Seizures....
<input type="checkbox"/> Blood Disorders	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Psychiatric
<input type="checkbox"/> Cancer	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Sexually Transmitted Diseases
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Skin Disorders
<input type="checkbox"/> Gastrointestinal	<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Genitourinary / Prostate	<input type="checkbox"/> Liver Problems, Hepatitis	<input type="checkbox"/> Other: _____

List Previous Surgeries: __None

Social History: __None

Tobacco Use Alcohol Use Street/Unprescribed Drugs

Family History: (F-father M-mother G-grandparent S-sibling A/U-aunt/uncle) __None

<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> Brain Aneurism
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Cancer/Leukemia	<input type="checkbox"/> Alzheimer's
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Psychiatric
<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Other: _____

Name and address of Pharmacy: _____

Patient/Legal Guardian Signature: _____ Date: _____