Hastings Convenient Care PC

PATIENT NAME: _____**DOB:** _____**AGE:** _____

CURRENT PHONE#_____**PARENT/ GUARDIAN NAME:** _____

CURRENT ADDRESS_____

NAME OF INSURANCE COMPANY _____

PRIMARY CARE PHYSICIAN: _____ **LOCATION**: _____

I would like my visit notes to be sent to the physician listed above. ☐ ***Yes*** ☐ ***No***

REASON FOR TODAY'S VISIT: _____

PHARMACY OF CHOICE: _____

CURRENT MEDICATIONS: please include prescriptions, over-the-counter medications, birth control pills, etc.:
(If you have brought a list of your current medications, we will make a copy and attach it to this form)

_____

_____

ALLERGIES: List any allergies to medications or other materials *(e.g. latex)*. What was the reaction?

_____ _____ _____ _____

_____ _____ _____ _____

CURRENT SYMPTOMS: Please read the following list of symptoms and mark all of those that you are experiencing ***today*** or with ***current illness***.

CONSTITUTIONAL
- Change Of Appetite
- Chills
- Fatigue
- Fever
- Sweats
- Weight Loss

CARDIOVASCULAR
- Chest Pain/Pressure
- Fainting
- Fluttering/Palpitations

NEUROLOGICAL
- Headache
- Light Headedness
- Numbness
- Poor Balance/Coordination
- Tingling
- Weakness

PSYCHIATRIC
- Anxiety/Nerves
- Depression

LYMPH
- Frequent Infections
- Lymph Nodes

EYES
- Blurred Vision
- Contact Lenses
- Double Vision
- Eye Discharge
- Eye Pain
- Wear Eyeglasses

ENT
- Dizziness
- Ear Pain
- Nasal Congestion
- Nasal Discharge
- Sneezing
- Sore Throat

RESPIRATORY
- Congestion
- Cough

MUSCULAR
- Joint/Muscle Pain
- Swelling

GI
- Abdominal Pain
- Diarrhea
- Nausea
- Rectal/Perirectal Complaints
- Urinary/Bowel Changes
- Vomiting

GU
- Discharge
- Frequent Urination
- Nighttime Urination
- Painful Urination
- Sexual Difficulties

SKIN
- Bruising
- Itching
- Laceration
- Rash
- Redness
- Skin sores

PLEASE READ AND SIGN BACK SECTION

Hastings Convenient Care PC

CONDITIONS OF OFFICE VISITS

CONSENT FOR TREATMENT

I understand that I may have a condition requiring diagnostic procedures, physical examination and/or medical treatment. I hereby voluntarily consent to such diagnostic procedures (including, but not limited to, laboratory testing, and x-ray testing), physical examination and such medical treatment as deemed necessary by the health care providers. I further acknowledge that no guarantees have been made to me as to the results of treatment or examination provided at HASTINGS CONVENIENT CARE P.C.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize HASTINGS CONVENIENT CARE P.C. to furnish my medical record requested information or excerpts to any insurance company or third party payer for the purpose of obtaining payment of the account, or any entity providing care to the patient (medical specialist, hospital, radiology, oncology, pathology, imaging center, skilled nursing facility, health care facility). Also, to any relative or caregiver listed below.

FINANCIAL AGREEMENT

I agree, whether I sign as the patient or as the legal representative of the patient that in consideration of the services rendered to the patient that I individually obligate the patient and myself to pay the account. In the event of a payment being made with a check that is returned to us from the bank due to insufficient funds there will be a $25.00 NSF check fee and payment must be made with either cash, money order or cashier's check made out to Hastings Convenient Care, P.C.. Failure to pay for services provided will result in your account being turned over to Collections. Arrangements that are different from this must be made with the office.

MEDICARE BENEFITS

Statement to Permit Payment of Medicare Benefits to Physician and Patient. I request payment of authorized Medicare benefits to me or on my behalf for any services furnished to me by HASTINGS CONVENIENT CARE P.C. I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

NON-COVERED MEDICARE

The Medicare program has certain patient exclusion from coverage including, but not limited to, routine diagnostic work up and some routine physical examinations. If your medical chart indicates your office visit is for any of the above and for which no Medicare benefits are allowable, please be advised that all charges incurred during your office visit will be your financial responsibility.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, AND IS THE PATIENT OR IS DULY AUTHORIZED BY OR ON BEHALF OF THE PATIENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

Signature of patient or authorized person Date

Relationship to patient

Witness