IMMEDIATE CARE MEDICAL CENTER
A PROFESSIONAL CORPORATION
CHICO • ORLAND

PREMIERE PRIMARY CARE

REGISTRATION FORM

Patient Name (Last, First, MI): _____

Mailing Address: _____ Apt. # _____ Home Phone Number: _____

City: _____ State: _____ Zip: _____ Alternate (Cell Work): _____

E-Mail Address: _____ Driver's License #: _____ SSN: _____

Date of Birth: _____ Age: _____ Sex: ☑ M ☐ F Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Emergency Contact: _____ Phone: _____ Relationship to Patient: _____

Employment status: ☐ Full-time ☐ Part-time ☐ Not employed ☐ Retired Ethnicity: Do you identify as Hispanic/Latino? ☐ Yes ☐ No

Race: ☐ Asian ☐ Black/African American ☐ Native American ☐ White/Caucasian ☐ Other: _____ Preferred Language: English

INSURANCE INFORMATION: - **We will request to scan your ID and insurance card**

Primary Insurance: _____ Subscriber Name: _____ Policy Number: _____

Relationship to Patient: _____ Social Security Number: _____ Date of Birth: _____

Secondary Insurance: _____ Subscriber Name: _____ Policy Number: _____

Relationship to Patient: _____ Social Security Number: _____ Date of Birth: _____

Are you being seen for a work-related injury or illness? ☐ Yes ☐ No

If yes, who is your employer? _____

Employer Phone Number: _____ Date of Injury: _____

Payment Policy

It is the policy of Immediate Care to request payment in full at the time of service. Acceptable payments include ATM, cash, check, charge card, or money order. Current insurance is acceptable, and as a courtesy, Immediate Care will bill the insurance company for reimbursement. If payment of the account has not been made by either the patient or the insurance company, within sixty (60) days, the patient is expected to pay the balance in full. Regardless of insurance coverage the patient is expected to pay (at time of service) any copays, unmet deductibles, charges for pharmaceuticals and all charges not covered by the policy.

Quest Diagnostics and Valley Clinical may be used for all outside laboratory services unless prior arrangements have been made.

Except for companies with which we have agreements, our office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. Regardless of any claim pending, if there is an open balance, a statement will be sent to you.

Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay accrual of attorney's fees and collection expenses. Your signature indicates that you are aware of Immediate Care's payment policy and gives permission to Immediate Care to bill your insurance, release any information necessary for billing and receive payment directly from the same.

Immediate Care does not accept Medi-Cal or CA Health and Wellness patients. Should you obtain Medi-Cal or CA Health and Wellness as your primary or secondary insurance while being treated at this office, we will no longer be able to accept you as a patient at Immediate Care.

I have read and understood and agree to the above statements.

Patient Name (Printed): _____ Patient/Representative Signature: _____

Relationship of Representative to Patient: _____ Date: _____

Patient Medical Record Number: _____ Reviewed by: _____

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PATIENT HIPAA ACKNOWLEDGEMENT

I am aware that I have the right to a copy of Immediate Care's Notice of Privacy Practices. I consent to the uses and disclosures of my health information as outlined in the Notice.

Patient Name _____ Patient Date of Birth _____

Signature of Patient or Representative _____ Date _____

Print Representative Name _____ Relationship of Representative to Patient _____

AUTHORIZATION TO RELEASE PHI TO FAMILY MEMBERS, FRIENDS AND/OR CARETAKERS

I acknowledge and agree that Immediate Care may use or disclose Protected Health Information to the person(s) I have indicated below. This information will include office notes, diagnostic tests and financial history report unless I state otherwise.

Full Name (printed)	**Date of Birth**	**Relationship**

Signature of Patient or Representative _____ Date _____

Print Name _____ Relationship of Representative to Patient _____

COVID-19 Screening Form

7/22/2020: Version 8

Name:_____

DOB: _____ AS#_____

Address:_____

Phone:_____

Car:_____ Parking spot #: _____

(color) (make) (model)

Screening Questions:

1. Have you been in contact with anyone with COVID-19? Yes or No

2. Are you experiencing a cough, fever, or shortness of breath? Yes or No

3. Have you or anyone in your household been tested for COVID 19? Yes or No
   If yes, did you receive results? Yes(P / N) or No

Results:

Positive Screening: Yes or No

Patient Cleared to enter clinic for evaluation?: Yes or No

Referred to ER with serious signs or symptom: Yes or No

Health Department Notified: Yes or No

Verbal consent to ICMC staff leaving voice mail message containing detailed medical information on the phone number listed below. This information may include, but not limited to, demographic information (partial or full name), and negative COVID test results. Yes or No

Phone:_____

Provider Name: _____

Provider Signature: _____

Date: _____