NEW PATIENT REGISTRATION

EMAIL DIGITAL INSURANCE CARDS

GUC: garrisonvilleurgentcare101@gmail.com

EMPUC: fdesk1610@gmail.com

(Updated: 08/01/2024)

PATIENT INFORMATION

Last: _____, First: _____ MI: _____

Date Of Birth _____ Age _____ Sex M ☐ F ☐ Marital Status: ☐ S ☐ M ☐ D ☐ W

Race: _____ Ethnicity: ☐ Hispanic/Latino ☐ NOT Hispanic/Latino **Language: _____**

Street Address: _____

City/State/Zip: _____

Phone #: (_____) _____ Cell # (_____) _____ Social Security #: _____-_____-_____

***Email Address** *(Required to sign up for our Patient Portal and Billing Statements)*:

_____

Primary Care Provider: _____ Primary Care Provider Phone Number: _____

Employer/Occupation: _____ Employment Status: ☐ FT ☐ PT ☐ Retired ☐ Other

PARENT/GUARDIAN INFORMATON

(Required if the patient is under 18 years of age)

Name: _____ *Relationship to Patient: _____

Street Address: _____

City/State/Zip: _____

Phone #: (_____) _____ Social Security #: _____-_____-_____

EMERGENCY CONTACT

***Emergency Contact Name: _____ *Relationship_____**

***Phone #: (_____) _____**

PREFERRED PHARMACY

(Please provide Pharmacy information, if not listed below)

☐ Dan's Pharmacy (Stafford) ☐ Walmart (Stafford) ☐ Walmart Neighborhood Market (Stafford) ☐ Publix (Stafford)
☐ CVS #1423 (Onville Rd) ☐ CVS #3396 (Shelton Shop) ☐ CVS (in Target/Stafford Market Place) ☐ Giant (Worth Ave)

Pharmacy Name: _____ Phone #: _____

Street Address: _____ City/State/Zip: _____

INSURANCE INFORMATION

Self-Pay (No Insurance): ☐ Y ☐ N

Payer (ex: BC/BS, Cigna): _____ Plan: _____

FOR TRICARE ONLY:

TRICARE PLAN: ☐ SELECT ☐ PRIME

SELF/SPONSOR STATUS: ☐ ACTIVE DUTY ☐ RETIRED ☐ RESERVE

Member ID/Policy #: _____Group #: _____

Is the Patient the Policy Holder? ☐ Yes ☐ No *If answer is NO, please answer the following:

*Policy Holder's Name: _____*Relationship to Patient: _____

*Date of Birth: _____ *Policy Holder's Social Security #: _____-_____-_____ *Sex: ☐ M ☐ F

*Policy Holder's Phone #: (_____) _____

*Policy Holder's address if different patient's: (Address, state, zip) _____

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

Payer (ex: BC/BS, Cigna): _____

Member ID/Policy #: _____Group #: _____

Is the Patient the Policy Holder? ☐ Yes ☐ No *If answer is NO, please answer the following:

*Policy Holder's Name: _____*Relationship to Patient: _____

*Date of Birth: _____ *Policy Holder's Social Security #: _____-_____-_____ *Sex: ☐ M ☐ F

*Policy Holder's Phone #: (_____) _____

*Policy Holder's address if different from above: (Address, state, zip) _____

WORKER'S COMPENSATION (IF APPLICABLE)

(MUST provide ALL the information below, PRIOR to being seen. You may be responsible for the visit, if incomplete.)

Case Manager Name: _____ Phone #: _____

Fax #: _____ Case Manager Email: _____

Claim/Case # (please provide both if available): _____

Address (to mail claims): _____

Incident Date: _____ Employer Name: _____

Supervisor/HR Name: _____ Employer Phone #: _____

RELEASE OF INFORMATION AUTHORIZATION

Please list family members or other with whom we may discuss your medical/account information.

☐ ***I CHOOSE NOT TO DISCLOSE MY INFORMATION WITH ANYONE***

NAME	**RELATIONSHIP**
_____	_____
_____	_____
_____	_____

Be sure to download our Patient Portal App in the APP STORE or Google Play

healow (eClinicalWorks)

PRACTICE CODE: FCCHBD

SCAN QR CODE TO TAKE YOU DIRECTLY TO PORTAL

(https://health.healow.com/GUC101)

Q&A:

- Q: Can I use the same healow app if my other doctor uses the same app?
  - A: YES, be sure to use OUR PRACTICE CODE: FCCHBD to add us to your account

NAME: _____ **DOB:** _____

MEDICAL HISTORY

CURRENT MEDICATION(S)/DOSAGE:

_____
_____
_____
_____

CHRONIC MEDICAL HISTORY:

_____
_____
_____
_____

FAMILY HISTORY:

Cancer:	☐ Yes	☐ No	☐ Mother ☐ Father ☐ Other: _____
Hypertension:	☐ Yes	☐ No	☐ Mother ☐ Father ☐ Other: _____
Heart Disease:	☐ Yes	☐ No	☐ Mother ☐ Father ☐ Other: _____
Diabetes:	☐ Yes	☐ No	☐ Mother ☐ Father ☐ Other: _____

SOCIAL HISTORY:

Tobacco Use:

Do you smoke? ☐ Yes ☐ No

- *If YES, how many cigarettes/cigars per day:*

  _____

Are you a former smoker? ☐ Yes ☐ No

Alcohol Use:

Do you drink alcohol? ☐ Yes ☐ No

- *If YES, how much per day:*

  _____

DRUG ALLERGIES:

_____
_____

OPERATIONS (Include month/year):

_____
_____
_____
_____

HOSPITALIZATIONS OTHER THAN SURGERY (Include month/year):

_____
_____
_____
_____

GARRISONVILLE URGENT CARE/EMBREY MILL PRIMARY AND URGENT CARE'S PRIVACY NOTICE

(This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.)

Uses and Disclosures of your Medical Information

Garrisonville Urgent Care/Embrey Mill Primary and Urgent Care is permitted to disclose your medical information without your authorization in the following cases. For purposes of your medical treatment, to obtain payment from your insurance carrier or to provide information to Federal, State and local health authorities.

Examples:

A. We release medical information to your health insurance carrier in the form of a claim to prove when, why and how we treated you for your medical condition. This includes releasing your medical information to your claim worker/case manager for Workers' Compensation

B: We release your medical information to specialists you are referred to for medical treatment, such as general surgeon or gynecologist.

C: If you are involved in a lawsuit/dispute, we must disclose medical information about you in response to a court or administration order. We also may disclose medical information about you in response to a subpoena or other lawful process from someone involved in a civil dispute.

D: We may release without your consent medical information to a law enforcement official:

- In response to a court order, warrant, summons, grand jury demand, or similar process
- In response to a request from law enforcement for certain information to help locate a fugitive, material witness, suspect, or missing person
- To report a death/injury we believe may be the result of criminal conduct
- To report suspected criminal conduct committed at Shifa Health dba Garrisonville Urgent Care and or Embrey Mill Primary and Urgent Care
- To comply with mandatory reporting requirements for violent injuries, such as gunshot wounds, stab wounds, and poisonings

E: If you are active duty member of the armed forces or Coast Guard, we must give certain information about you to your commanding officer or other command authority so that your fitness for duty or for a particular mission may be determined

Garrisonville Urgent Care/Embrey Mill Primary and Urgent Care will not disclose your medical information for uses other than those mentioned above without your prior written authorization. You may revoke such authorization expires 30 days from the date you sign it. You may cancel the authorization prior to the 30-day expiration date by providing Garrisonville Urgent Care/Embrey Mill Primary and Urgent Care a written request.

Garrisonville Urgent Care/Embrey Mill Primary and Urgent Care Patients have the following Individual Privacy Rights:

1. The right to request restrictions on certain uses and disclosures including a statement that Garrisonville Urgent Care/Embrey Mill Primary and Urgent Care is not required to agree with the request. Example: You may request no information be released to your former employer or spouse.
2. The right to received confidential communications of protected health information at alternative sites. Example: If Garrisonville Urgent Care/Embrey Mill Primary and Urgent Care had multiple offices, the offices could exchange your records without an authorization.
3. The right to inspect and copy protected health information. Example: You may inspect and copy your medical records upon provision of proper identification and signature of release of information authorization.
4. The right to request amendments to protect health information. Example: After review of your medical record, you may find an error in the documentation. You may insert a letter / statement identifying the error and the correction according to your interpretation. The statement will be made part of the permanent medical record. The statement will be included in all future releases of medical records authorized by you. Garrisonville Urgent Care/Embrey Mill Primary and Urgent Care has 60 days from date of receipt to act on the request.
5. The right to receive an accounting of certain disclosures of protected health information. Example: You may request a list of all parties to whom we have released your medical records. Garrisonville Urgent Care/Embrey Mill Primary and Urgent Care has 60 days from date receipt to act on the request.
6. The right to obtain a copy of this Privacy Notice.

Garrisonville Urgent Care/Embrey Mill Primary and Urgent Care Duties to Protect Our Patients' Medical Information

1. Garrisonville Urgent Care/Embrey Mill Primary and Urgent Care must abide by the terms of this notice as soon as possible.
2. Garrisonville Urgent Care/Embrey Mill Primary and Urgent Care is required by law to maintain the privacy of protected health information and provide individuals with notice of its legal duties and private practices with such information.
3. Garrisonville Urgent Care/Embrey Mill Primary and Urgent Care reserves the right to change the terms of this notice as required by law or its' own internal practices and to make the new notice provision effective for all protected health information. The revised notice will be posted in our office and distributed to each patient at the time of their next visit to our office.

Patient Complaints Regarding the Release of Medical Information.

1. Patients may complain to the Garrisonville Urgent Care/Embrey Mill Primary and Urgent Care Privacy Officer. The complaint must be in writing and addressed to the Privacy Officer.
2. Patients will not be retaliated against for filing a complaint against Garrisonville Urgent Care/Embrey Mill Primary and Urgent Care. Acknowledgement of Privacy Statement.

Participating Insurances and other PPO's:

I understand that I will be held responsible for all fees that my insurance does not cover. This includes but is not limited to all deductibles, co-insurance, and co-pays. As well as fees incurred for in house labs and DME supplies.

HMO (Health Maintenance Organization) plan with a PCP:

An office staff member has informed me that my insurance carrier for the date of service listed above requires a referral and/ or prior authorization for medical services at this facility. It has been explained to me that I have the option to receive medical care today but will then be fully responsible for the total charges incurred.

I have elected to receive medical care today and I will be fully responsible for the charges if my insurance carrier denies my claim for any reason.

POS (Point of Service) plan with or w/o out-of-network benefits:

An office staff member has informed me that my insurance carrier for the date of service listed above is one in which I have the option to receive medical care from this facility without a referral or prior authorization.

I have elected to utilize my out-of-network benefits of my point of service coverage. I agree to be responsible for any higher copayment/ co-insurance amount I understand that I will be fully responsible if my insurance carrier decides to apply the charges to a separate out-of-network deductible or denies the claim for any reason.

Other NON-PAR (Participating) insurance plan with or w/o out-of-network benefits:

An office staff member has informed that my insurance carrier for the date of service listed above is one in which this facility does not participate as a PPO/in-network provider. I understand that my coverage via my insurance is a contract between my insurance carrier and me only. This facility is not a party to that contract.

I have elected to utilize my out-of-network benefits. I agree to be responsible for any higher co-payment, Co-insurance amount. And I understand that I will be fully responsible if my insurance carrier decides to apply the charges to a separate out-of-network deductible or denies the claim for any reason.

General Insurance Information:

1. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances and non-covered services.
2. It is your responsibility to keep us updated with your correct insurance information. If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to your correct plan for reimbursement.
3. It is your responsibility to understand your benefit plan with regard to, for instance, covered services and participating laboratories.

Examples:

A: Not all plans cover annual healthy (well/routine) physicals and laboratory screenings. If these are not covered, you will be responsible for payment.

B: Some plans have a limit as to the number of allowed well/routine visits/services/screenings per year. If the number of visits is exceeded, your insurance company will not pay; you will be responsible for the payment.

C: Some plans are laboratory specific. It is your responsibility to inform the provider/medical assistant which laboratory your samples need to be sent to.

4. It is your responsibility to know if a written referral or authorization is required to see a specialist, whether preauthorization is required prior to a procedure, and what services are covered.

Tricare Prime:

Please be sure to update your PCM to **Dr. Galam Khan**, if you would like us to continue treatment as your PCM.

Self-Pay Patients/Uninsured:

Payment is due the same day services are rendered. We **DO NOT** bill patients for Self-Pay Visits.

Payment

1. If you **DO NOT** have insurance, **DO NOT** provide an insurance card or **DO NOT** provide a social security number at the time of service, you will be considered a self-pay patient. Self-pay patients are required to pay for services in **FULL** at the time of visit.
2. If we **DO NOT** participate with your insurance plan, payment in full is required from you at the time of your visit. We will supply you with an invoice (one day after the visit) that you can submit to your insurance for reimbursement.

* Patient balance **MUST BE** paid in full, prior to next visit.

Fees

1. Non-physician requests for medical records will assess administration fees, according to the current state regulations. The fee is due at the time the records will be picked up.
2. Co-payments are due at the time of service.
3. Any balance outstanding longer than 90 days will be forwarded to a collection agency. You agree to reimburse us the fees of any collection agency, which may be based on a percentage of account balance, and all cost and expenses, including reasonable attorney's fees, we incur in such collection efforts.
4. A $35 fee will be charged for any checks returned for insufficient funds.

I hereby assign, transfer, and set over to Garrisonville Urgent Care/Embrey Mill Primary and Urgent Care all my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I further agree in the event of non-payment, to bear the costs of collection which may be based on a percentage up to 30%, and/or court costs and reasonable legal fees should be required.

_____	_____	_____
PRINTED NAME OF PATIENT/PARENT/GUARDIAN	**SIGNATURE OF PATIENT/PARENT/GUARDIAN**	**DATE**

POLICIES AND PROCEDURES

Please read and initial each statement:

- _____ Please make sure we have your most recent insurance (if applicable), pharmacy (where you would like your prescriptions electronically sent), address, phone number (for appointment reminders) on file.
- _____ The providers work hard to stay close to the appointment schedule but do recognize urgent situations can arise during office hours. Please be patient and we will be right with you.
- _____ **PROVIDER SCHEDULE**: Please be aware that provider schedules fill quickly, therefore please schedule your appointments promptly.
- _____ **PATIENT BALANCE:** Patient balance MUST be paid in full, prior to next appointment.
- _____ **FOLLOW-UP APPOINTMENTS**: We recommend that you schedule your follow up appointment right after your current appointment to ensure you have a timely follow up appointment for medication refills.
- _____ **CANCELLATION/RESCHEDULE:** Please be sure to call at least 24 HOURS in advance to cancel or reschedule your appointment. Failure to comply with this policy, MAY result in a **NO-SHOW FEE of $50**. Insurance does not pay for missed appointments.
- _____ **PRIMARY/URGENT VISIT** *(if applicable):* Keep in mind that your copay amount is dependent on the type of visit. MOST "Walk-In" visits will be considered as an URGENT CARE VISIT. That is why we strongly recommend our "PRIMARY CARE" patients to make an appointment, especially for medication refills.
- _____ **MEDICATION REFILLS:** Please allow two business days, for medication refill to be reviewed/filled. Be mindful of last time you had an "in-person" appointment to review your medication and the last time you had your annual bloodwork done.
    - Controlled Medication: The providers would like to see you once a month.
    - Maintenance Medication: The providers would like to see you every three months.
    - Annual Bloodwork: This needs to be done once a year. You must "FAST" for this bloodwork and it is highly recommended that you get it done first thing in the morning.
- _____ **FORMS/LETTERS:**
    - Blank forms WILL NOT be accepted. We will only accept forms that have the patient's name and medical history portion filled out.
    - Form completion is usually 3-5 business days. We receive many forms request each week.
    - Due to HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) regulations, forms will be released to the patient/guardian only (unless noted otherwise). We will mail the forms to the home address on file at your request. Please provide us with a stamped and self-addressed envelope for this purpose.
    - There is no charge for forms submitted at the time of the appointment. Please plan ahead and have your forms ready prior to your appointment.
        - $25 per form (outside of your appointment) *Please note that the front staff DOES NOT have the authority to alter, reduce or waive charges. Fees are collected at the time of form pick-up.
        - Request must be in writing with a release of information authorization by the patient/guardian. Written request must include the following: the purpose/content of the letter as well as the title, name, and address to whom the letter is intended. Letters to consulting physicians/hospitals will not incur a fee. All other letters will incur a $25 fee. Please include a self-addressed stamped envelope if you would like a copy of the letter mailed to you.

PRINT NAME: _____ DATE: _____

URGENT CARE VISIT vs. PRIMARY CARE VISIT

When you can't see your PRIMARY CARE PHYSICIAN or normal HEALTH CARE PROVIDER, a trip to an Urgent Care is usually the most cost-effective move.

Typical URGENT CARE services include minor medical treatments that you can get treated at a doctor's office.

Typical PRIMARY CARE services include continuing care of varied medical conditions and treatments of an array of illness and injuries and health concerns.

Please be aware that most "walk-in" appointments will be considered as URGENT CARE visit, which may accrue a higher charge/copay. That is why, we urge patients to schedule their follow-up appointments, ahead of time. Based on your insurance, you may have a different copay amount depending on visit type.

URGENT CARE SERVICES
(EXAMPLES)

- Allergic Reaction
- Nausea
- Conjunctivitis
- Rash
- Diarrhea
- Sinusitis
- Ear Infections
- Fever
- Insect Bites
- Migraines
- Vomiting
- UTI
- Upper Respiratory Infection
- Earache
- Sore Throat
- Bronchitis
- Flu/Covid Testing
- Vaginitis
- Minor Injury
- Abscess and drainage
- Shortness of breath

PRIMARY CARE SERVICES
(EXAMPLES)

- Routine Medication Prescription
- Diabetes
- COPD
- Asthma
- Depression
- Cardiovascular Screening
- Birth Control Services
- Pap Smears
- Blood Pressure Monitoring
- Weight Management
- Nutrition
- Hypolipidemia
- Yearly Physicals
- Cancer Screening