FAIRFAX URGENT CARE AND HEALTHPLEX

8191 Strawberry Lane Suite 6,
Falls Church, VA 22042
Telephone: 703-493-0404
www.FairfaxUrgentCare.net

GENERAL INFORMATION

Date: _____

Name: _____

Address: _____

_____ Apt#_____

City: _____ State: _____ Zip: _____

Home# _____ Work# _____ Cell Number: _____

Date Of Birth:_____ Email: _____

Gender: Male Female

Pharmacy Name/Number: _____

How did you hear about us?

____Google ____Yelp ____Zocdoc ____Mailer/Postcard

____Banner ____Bing ____Street ____Friends and Family

____Other_____

PATIENT REGISTRATION

Welcome to our clinic. In order to serve you properly, we will need the following information. All information will be strictly confidential. ***PLEASE PRINT.***

Patient's Name	Birth Date ___/___/_____	Patient's Social Security#	Occupation:

Emergency Contact:	Reason for Visit:	Employer Name:	Employer Contact:

Employer Address:

Medical Insurance

Primary Insurance Company Name & Address

Subscriber Name	Subscriber birth date ___/____/_____	Member ID	Group#

Person Financially Responsible For This Account:	Relationship to Patient:	Phone Number:

Responsible Party's Social Security #	Responsible Party's Date Of Birth: * _____/_____/_____

Secondary Insurance Company Name & Address

Subscriber Name	Subscriber birth date ___/____/_____	Member ID	Group#

Information Release/Authorization to Treat/Clinic

Lifetime Assessment of Benefits

I authorize payment of medical benefits to Fairfax Urgent Care for any service furnished. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize you to My Insurance Company or its agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits. I also authorize that interdisciplinary team to perform the treatment or procedure approved by my referring physician. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any medical treatments and/or procedure. I understand and consent the use of electronic pharmacy/Medical records to obtain my prior prescription history, if available, in order to receive medical care at this clinic. I fully understand and have received a copy of my Patients Rights & Responsibilities and this facility's grievance procedure. I understand & acknowledge this clinic does not allow the use of photography; video or audio recording in exam rooms & agree to abide by this policy. I accept this polices & give consent to medical treatment.

_____

Patient, Parent Or Guardian Signature (if child is under the 18 years of age) **Date:**

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MEDICAL FORM

Name: _____ DOB: _____

Medications: **Drug Allergies:**

Family History

Cancer:	Y	N	Mother ☐	Father ☐	Other ☐	
Diabetes:	Y	N	Mother ☐	Father ☐	Other ☐	
Heart disease:	Y	N	Mother ☐	Father ☐	Other ☐	

Tobacco/AMT: **Alcohol/AMT:**

Chronic Medical History: **Tetanus Booster:**

Past Medical History Surgery/Date:

FAIRFAX URGENT CARE PRIVACY NOTICE 8191

STRAWBERRY LN, SUITE 6 FALLS CHURCH VA 22042

PHONE: (703)4930404 FAX: (571)730-4838

The Department of Health and Human Services, office of Civil Right, under the Public Law 104-191, (the Health Insurance Portability and Accountability Act of 1996) (HIPAA), mandates that we issue the new revised Privacy Notice to our patients. Meets all current requirements as it relates to Standards for Privacy of Individually Identifiable Health Information (IIHI); affecting our patients. You are urged to read this notice.

As part of the Privacy Standard implemented on April 14, 2001, you are required to provide this office with new, signed and dated, Consent Agreement. Every patient must receive our new Privacy notice and execute a new Consent Agreement before this office may use your information for treatment, payment, or other health (FPO).

Our Privacy Notice informs you of our use and disclosure of your Protected Health Information (PHI), defined as: “any information, whether oral or recorded in arty medium, that is either created or received by a health care provider, health plan, public health authority, employer , life insurance company, school or university or clearinghouse and that relates to the past, present or future physical or mental health or condition of an individual, the provision of health care and to an individual, or the past, present or future payment for the provision of health care to an individual”.

Our office will use or disclose your PHI for purposes of treatment, payment and other healthcare purposes as required to provide you the best quality healthcare services that we offer to the extent permitted by your Consent Agreement or in such specific situations, ~ your signed and dated Authorization. It is our policy to control access to your PHI; and even in cases where access is permitted, we exercise a “minimum necessary information” restriction to that access. We define the minimum necessary information as the minimum necessary to accomplish the intent of the request.

An Authorization differs from a Consent Agreement in that it is very specific with regard to the information allowed to be disclosed or used, the individual or entity to which the information may be disclosed to, the intent for which it may be disclosed, and the date that it was initiated which may include the duration of the authorization. This is a form, separate from the consent Agreement, and usually used only specific request for information. In the event of a non healthcare related request for personal health information this office will request you to complete art Authorization Form.

You, as our patient may revoke any Consent Agreement or Authorization at any time and all use and disclosure and administration of related healthcare services will be revised accordingly, with the exception of matters already in process as a result of prior use of your PHI. To revoke either the Consent Agreement or the Authorization you will have to provide this office with a written request with your signature and date and your specific instructions regarding and existing Authorization or consent Agreement. Any revocation will not apply to Information already used or disclosed.

If you had a "personal representative" initiate as Authorization you may revoke that authorization at any time.
You, the patient have access to your health care information and may request to examine your information, may request copies of your information, and under the law you may request amendments to your information.

The physician or principal will exercise professional judgment with regard to requests for amendments and is not bound by law to make arty changes to the information: If the physician or professional agrees with the request to amend the information, we are bound by law to abide by the changes. In limited circumstances, the Privacy Standard permits, but does not require, covered entitles to continue certain existing disclosures of health information without individual authorization for specific public responsibilities.

These permitted disclosures include: emergency circumstances; identification of the body of a deceased person or to assist in determining the cause of death: public health needs; research, generally limited to when a waiver of authorization is independently approved by a privacy board or Institutional Review Board; oversight of the health care system- judicial and administrative proceedings; limited law enforcement activities; and activates related to national defence and security. These are specific state laws that required the disclosure of health-Information related to Hepatitis C, and AIDS. Where the state laws are more stringent than HIPAA Privacy Standard, the state laws will prevail.

All of these disclosures could occur previously under former laws and regulations however The Privacy Slandered established new safeguards and limits. If there is no other law requiring that your information be disclosed, we will use our professional judgments to decide whether to disclose any information, reflecting our policies and ethical principles.

On some occasions we may furnish your PHI to third party. This could be an insurance company for the purpose of payment or another health care provider for further treatment or additional services. Although we will institute a “chain of trust” contract and monitor our business associates contracts with us, we cannot absolutely guarantee that they will not use or disclose your PHI in such a way as to violate the Privacy Standard.

Although the law requires a signed dated Privacy Notice, this office does not demand that you sign this agreement as a condition of receiving care. It is the law that your rights are communicated in this manner.

It is our practice in retain information about non-healthcare related requests for yours health care information for a period of six years.

In complying with the Privacy Standards, we have appointed a privacy officer, trained our Privacy officer and the staff in the law, and implemented policies to policies to policies to protect your PHI. We have instituted privacy and security protects your IHI. This office is taking and continuous to monitor and improve steps for the protection of your information and to remain in compliances with the law.

FAIRFAX URGENT CARE

Consent Agreement

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) does not require that health care providers obtain a consent agreement as it relates to the use and disclosure of individually identifiable health information (IIHI), but may practices will continue to use the Consent Agreement for other purposes.

Though not necessary to have your consent to allow us to use and disclose your IIHI to others who will treat you or support in providing you quality health care services, it is important to have your consent to use and disclose your IIHI to health care plans to ensure accurate and timely payments for the services rendered. The law requires that we inform you of our policy regarding the protection of your IIHI through our Privacy Notice. We may already have a consent agreement from you. Please refer to our Privacy Notice for a full explanation of how this office will protect your individually identifiable health information (IIHI).

Thank you for your continued confidence in our practice and for supporting our new requirements.

The following is a statement that allows us the necessary latitude to work within the new requirements.

I_____, have been presented with a Privacy Notice explaining my rights regarding my identifiable health information (IIHI). I consent to the use and/or (TPO). Other uses of my IIHI will require an authorization from me for the specific intention of disclosure.

Patient:_____ Date: _____

THANK YOU!