Champlain Medical Urgent Care
New Patient Welcome Sheet

How did you hear about Champlain Medical Urgent Care:

☐ Friend ☐ Drive By ☐ Google ☐ Yelp ☐ Employer ☐ Insurance ☐Other: _____

Why are you here today?

☐ Urgent Care ☐ PCP F/U ☐ Work Injury ☐ Work Surveillance ☐ Drug Screen ☐ Pre-employment ☐Other: _____

Chief Complaint (please describe in your words your symptoms or injury) _____
_____

If work injury, please note date of injury: _____

Patient Information:

SS# _____ First Name: _____ MI _____ Last _____

Address: _____ City:_____ State: _____ Zip:_____

Phone: _____ Cell # (if different) _____ Email: _____

Date of Birth: _____ Gender: M F U Primary Care Practitioner:_____

How do you plan to pay for your services today? (please select appropriate box)

☐ Self-Pay ☐ Bill my insurance which is: _____ and my ID is _____
And the subscriber for the policy is _____ and they are related to you as a
☐ self ☐ spouse ☐ parent ☐ other and their date of birth is _____

☐ I was hurt at work and my Employer is _____ and the contact for further information regarding my claim would be _____ and their phone number is _____

☐ My employer or potential employer has sent me here for these services

Assignment of Benefits – Financial Agreement:

I hereby authorize this office and its staff and practitioner to examine and treat my condition as the practitioner deem appropriate and I give authority for these procedures to be performed. I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment of services by this office. You are required to leave a credit/debit card on file that will be charged only after submission to your insurance carrier if applicable. Should collection of past due amount become necessary I will become responsible for all charges, fees and attorney fees. I (we) hereby authorize the practitioner to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Patient/Guardian _____ Date: _____

Consent to Treat a Minor:

I (we) being the parents, guardian or custodian of the minor being: _____ do hereby authorize, request and direct this office, its practitioners and staff to perform examinations, and any treatment that in their judgement is deemed advisable or is required while said minor child is under care of this office's doctors and staff until legal age. All charges for service and care given to said minor child will be charged directly to me (us) and I (we) will personally be responsible for payment of them. I (we) hereby authorize the practitioner to release all information necessary to secure payments of benefits. I authorize the use of this signature on all insurance submissions.

Parent, Guardian, or Custodian Signature: _____ Date: _____

Relationship to Patient: _____ Witness: _____ Date: _____

Champlain Medical Urgent Care

Patient Name: _____

Yes	No	List allergies you have:
		Drug Allergies (specify):

Yes	No	List medications you take:
		Medications (specify):
1.		
2.		
3.		
4.		
5.		

Yes	No	Do you have any of the following?
		Cancer History
		Asthma
		Heart Disease
		Depression / anxiety
		Diabetes
		High Cholesterol
		High Blood Pressure
		Heartburn
		Other:

Yes	No	Have you had Surgeries or Operations?
		Surgeries (specify):

Yes	No	Do parents/siblings have any of the following?
		Cancer or Leukemia:
		Diabetes:
		Heart Disease:
		High Blood Pressure:
		Strokes:
		Mental Illnesses:

Yes	No	Do you use alcohol, drugs or smoke?
		Tobacco Use: How much ? _____ Day.
		Alcohol Use: How much ? _____ Day..

Yes	No	Are you employed?
		Employer:
		Position?

Yes	No	Menstrual History (woman):
		Are you pregnant?
		Last menstrual date?
		Last pap smear date?
		Left or right handed? ❑ Left ❑ Right
		Last Tetanus shot date?

Are you experiencing any of the following conditions/symptoms TODAY?

Yes	No	CONSTITUTIONAL
		Change in appetite
		Chills
		Fatigue
		Fever
Yes	**No**	**EYES AND VISION**
		Blurred vision
		Eye pain
Yes	**No**	**EARS, NOSE , THROAT, TEETH**
		Dizziness
		Ear pain
		Nasal congestion
		Sore throat
Yes	**No**	**CARDIOVASCULAR / HEART**
		Chest pain or pressure
		Fainting
		Irregular heart beat
Yes	**No**	**RESPIRATORY / LUNGS**
		Cough
		Shortness of breath
		Wheezing
Yes	**No**	**GASTROINTESTINAL SYSTEM**
		Abdominal pain
		Diarrhea
		Nausea
		Urinary / Bowel changes
		Vomiting

Yes	No	GENITOURINARY
		Frequent urination
		Painful urination
Yes	**No**	**MUSCULOSKELETAL**
		Joint pain
		Muscle pain
Yes	**No**	**SKIN**
		Rash / Itching
		Skin sores
Yes	**No**	**NEUROLOGICAL**
		Headache
		Light headedness
		Numbness
		Poor balance
		Tingling
		Weakness
Yes	**No**	**PSYCHIATRIC**
		Anxiety/Nerves
		Depression
Yes	**No**	**ENDOCRINE SYSTEM**
		Diabetes
		Hyper or hypothyroid
Yes	**No**	**HEMATOLOGIC/BLOOD DISORDERS**
		Anema
		Swollen glands
Yes	**No**	**IMMUNE SYSTEM**
		Frequent Infections

HOW CAN WE HELP YOU TODAY?

Signature: _____ **Date:** _____

Patient Vitals: Chief Complaint _____ Height ____ Weight ____ Temp ____ BP ____ / ____ Pulse ____ O2sat % ____ Room ____

HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

_____ Date: _____

Printed Name

_____

Signature

PATIENT FINANCIAL POLICY FOR CHAMPLAIN MEDICAL ASSOCIATES

Patient Name:_____ DOB: _____

Patient agrees to pay for all portions of services due in full at the time services are provided by our office.

Patient Financial Class Policies:

You are required to present a valid insurance card at every visit and as needed throughout your care.

Commercial Insurance Carriers: We bill most insurance carriers for you if proper paperwork is provided to us. Any outstanding balances, co-payments and deductibles are due prior to checking in for your appointments. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for your care. If an insurance carrier has not paid within 60 days of billing, fees are due and payable in full from you.

Medicare: Our office is a medicare participating provider and we will bill Medicare for you. We will bill your secondary insurances that automatically crossover through the CSM (Medicare system). If your secondary insurance does not crossover it is the patient's responsibility for filing these claims. As a courtesy we will mail you a claim form that you can then send to your insurance carrier to receive reimbursement. Any outstanding balances and deductibles are due prior to your appointments. Any co insurance and non covered service will be due as service is rendered.

Worker's Compensation: If your visit is work-related we will need the case number, date of injury, and carrier name prior to your visit in order to bill the worker's compensation company.

Methods of Payment:

Our office accepts the following payment methods:

Cash, personal check, Visa, Mastercard and patient financing options for those patients who are credit worthy.

For returned checks we assess a $25.00 NSF charge and report to the local district attorney's office checks that are not paid within 2 weeks of being returned to our office.

Appointments must be cancelled at least 24 hours in advance to avoid $60 "no show" fee. Comprehensive visits not cancelled are billed out at $60 "no show" fee.

Co pays not paid at the time of service will be subject for a $5.00 extra processing fee.

If not paid according to terms the patient understands that our office reports to an outside collection agency. In the event that your account is turned over for collections, patient agrees to pay all additional fees accessed in the collection of the debt. These fees include collection agency fees and attorney fees.

The patient is ultimately responsible for all fees for services. I have read, understood and agreed to the above financial policy for payments or professional fees.

Signature_____ Date:_____