**LAKE REGIONAL URGENT CARE**

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| **PLEASE PRINT CLEARLY – PROVIDE PHOTO ID AND INSURANCE CARDS**  **LRUCTESTING@GMAIL.COM** |

**IS THIS RELATED TO ONE OF THE FOLLOWING (CIRCLE):**

**AUTO ACCIDENT WORK COMPENSATION PRE-OP CLEARANCE**

**PATIENT INFORMATION**

FIRST NAME**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MIDDLE INITIAL: \_\_\_\_\_ LAST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_

DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_ SEX: \_\_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_\_\_

BILLING ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_ STATE: \_\_\_\_\_\_\_\_\_ ZIP CODE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IF PATIENT UNDER 18 YRS OF AGE PLEASE PROVIDE PARENT OR LEGAL GUARDIAN INFORMATION:**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_ ZIP CODE: \_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SOCIAL SECURTIY NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT/RELEASE OF MEDICAL INFORMATION:**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WE OFFER AESTHETICS, WELLNESS & ANTI - AGING**

***CIRCLE WHICH SERVICES WE CAN HELP YOU WITH***

* URINARY FREQUENCY
* ANTI - AGING WELLNESS
* FACE
* HANDS
* THIGHS
* LOWER LEGS
* HAIR LOSS
* NECK
* ARMS
* HORMONE REPLACEMENT THERAPY
* BODY COMPOSITION
* WRINKLES
* BOTOX FILLERS
* MUSCLE BUILDING
* SEXUAL FUNCTION
* SKIN CORRECTION
* BODY CONTOURING

**LAKE REGIONAL URGENT CARE**

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CARDIOLOGIST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REASON FOR VISIT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IS THIS RELATED TO AUTO, WORK COMP, OR PRE-OP CLEARANCE? **⃝ YES ⃝ NO**

IF YES, YOU MUST PROVIDE ADDITIONAL IMPORTANT INFORMATION SUCH AS CLAIM/BILLING INFO, ANY RELATED TREATMENT NOTES OR A PRE-OP ORDER TO BE SEEN. PLEASE SEE RECEPTIONIST FOR DETAILS.

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| **PLEASE LIST ALL MEDICAL INFORMATION, DO NOT LEAVE BLANK. IF IT DOES NOT APPLY, CHECK NONE.** |

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**MEDICAL HISTORY (INCLUDE REASON FOR TAKING MEDICATIONS): ⃝ NONE**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST SURGERIES: ⃝ NONE**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS: ⃝ NONE**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES: ⃝ NO KNOWN MEDICATION ALLERGIES**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU VAPE/SMOKE? **⃝ YES ⃝ NO** IF YES, HOW MANY PACKS PER DAY? \_\_\_\_ HOW MANY YEARS? \_\_\_\_

DO YOU DRINK ALCOHOL? \_\_\_\_\_\_\_\_\_ IF YES, HOW MANY DRINKS PER WEEK? \_\_\_\_\_\_\_\_

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| **PATIENT RESPOSIBILTY DISCLOSURE STATEMENT** |
| **PLEASE READ AND SIGN BELOW**  Your signature below forms a binding agreement between Lake Regional Urgent Care (the provider of medical services) and the Patient who is receiving medical services, or the Responsible Party of minor patients under age 18. The Responsible Party is the individual who is financially responsible for payment of medical bills. |
| **HIPPA:** HIPPA notices are attached to the clipboard provided. If you would like a copy, please notify our staff. If not, signing below acknowledges that you have waived the written copy. |
| **Payments for Services:** All payments and past due balances are due at the time of service. If your insurance requires any additional co-payments you will be responsible for payment and will be billed. As we are an Urgent Care facility, the urgent care co-pay will apply. If no urgent care co-pay, the specialist co-pay will apply.  \*Returned checks will be assessed a $35 returned check fee and checks will no longer be accepted by the patient\* |
| **HMO Plans:** If my insurance plan is a HMO, I understand that an authorization from my primary care physician may be required for my insurance company to cover services provided by Lake Regional Urgent Care. I agree to contact my PCP to obtain authorization for services. If not and my plan declines coverage, I will assume responsibility for the charges incurred. |
| **Out of Network Plans:** I acknowledge that some insurances or plans my not pay for my services at Lake Regional Urgent Care. I agree to pay balance which results from out-of-network charges. |
| **Authorization to pay benefits to the physician/facility:** I authorize payment for medical services provided directly to Lake Regional Urgent Care. All insurance checks that may go directly to the patient MUST be signed over to Lake Regional Urgent Care for payment for services rendered. Failure to do this will result in the patient receiving a bill for services. |
| **Patient Refunds:** All Patient refunds will be kept as a credit of the patient’s account toward their next visit unless a refund is initiated by the patient. The following criteria must be met prior to issuing a patient refund: There are no outstanding insurance claims or patient balances on the account. **CONTACT BILLING OFFICE AT 352-315-1651** |
| **Durable Medical Equipment:** As we are an Urgent Care facility, we have urgent care contracts with most major health insurance companies. In abiding with our contract guidelines, we CANNOT bill insurance companies for DME (Durable Medical Equipment) such as crutches, slings, braces and extremity immobilizers. We carry some of these products as a convenience, and they are available to our patients as an out-of-pocket expense and are non-refundable. By signing, you acknowledge your understanding that any DME supplies cannot and will not be submitted to your insurance company by Lake Regional Urgent Care. |
| **INFORMED CONSENT:** In order to enhance patient’s care and experience, Lake Regional Urgent Care may contact you after your visit in order to request feedback of your experience by phone or email. By signing below, you understand and agree to be contacted in this manner with regards to our experience related to this visit and any future visits. |

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| **CONSENT TO TREAT / RECEIPT OF DOCUMENTS** |

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| **CONSENT TO TREAT:** The above information is true to the best of my knowledge. Insurance policy limitations may not cover today’s visit. I understand and agree that I am responsible for paying any non-coved charges, deductibles and co-payments. I authorize Lake Regional Urgent Care or insurance company to release any information required to process my claims of to release any medical records to additional Providers as required. Additionally, I have read and understand my Health Information Patient Privacy Rights.  **RECEIPT OF DOCUMENTS:** BY SIGNING BELOW I ALSO ACKNOWLEDGE THAT I CAN REQUEST A COPY OF HIPPA PRIVACY STATEMENT. |

**PATIENT NAME (PRINT): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT/GUARDIAN SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

UPDATED 4/2024