CITY URGENT CARE
DETROIT

13403 W 7 MILE RD, STE A, DETROIT, MI 48235 (313) 308-2444

# PATIENT PRE-SCREENING QUESTIONNAIRE

We appreciate your cooperation and patience in helping to keep our patients and staff safe and healthy.

Have you traveled outside the U.S. in the past 14 days? ◯ YES ◯ NO
If yes, where? _____

Have you or someone you know been in personal contact with a person infected with Coronavirus in the past 14 days? ◯ YES ◯ NO

Have you had a Covid test in the past 10-14 days? ◯ YES ◯ NO

Have you EVER had Covid? ◯ YES ◯ NO
If yes, when? _____

IN THE LAST 48 HOURS:
Have you had a fever (100.4°+)? ◯ YES ◯ NO

Have you experienced any:
Coughing? ◯ YES ◯ NO
Sore Throat: ◯ YES ◯ NO
Difficulty Breathing? ◯ YES ◯ NO
Muscle Aches? ◯ YES ◯ NO
Stomach Pain? ◯ YES ◯ NO

Print Name:_____

Signature:_____ Date:_____

**Please return this form to the front desk when completed**

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# PATIENT REGISTRATION

| LAST NAME | FIRST NAME | M.I. |
|---|---|---|
| | | |

| DOB | SOCIAL SECURITY | SEX<br>M F | MARITAL STATUS:<br>SINGLE MARRIED<br>WIDOWED DIVORCED |
|---|---|---|---|
| | | | |

| ADDRESS, CITY, STATE, ZIP CODE |
|---|
| |

| HOME PHONE | CELL PHONE | EMAIL |
|---|---|---|
| | | |

| IN CASE OF EMERGENCY (FIRST, LAST NAME): | RELATIONSHIP TO PATIENT | PHONE NUMBER |
|---|---|---|
| | | |

## PRIMARY INSURANCE

| NAME OF INSURANCE | MEMBER ID | GROUP NUMBER |
|---|---|---|
| | | |

| SUBSCRIBER NAME (FIRST, LAST) | SUBSCRIBER DOB | RELATIONSHIP TO PATIENT |
|---|---|---|
| | | |

## SECONDARY INSURANCE

| NAME OF INSURANCE | MEMBER ID | GROUP NUMBER |
|---|---|---|
| | | |

| SUBSCRIBER NAME (FIRST, LAST) | SUBSCRIBER DOB | RELATIONSHIP TO PATIENT |
|---|---|---|
| | | |

**OPTIONAL INFORMATION:** At City Urgent Care, our goal is to exceed the highest standard of quality patient care. As a part of that goal, we are participating in the "Meaningful Use" program by the Centers for Medicare & Medicaid Services, which aims through a set of objectives to improve access to healthcare, clinical quality, and patient outcomes. Meeting these objectives includes recording Race and Ethnicity as defined by the United States Census Bureau.

**RACE:** AMERICAN INDIAN OR ALASKA NATIVE ASIAN BLACK OR AFRICAN AMERICAN
NATIVE HAWAIIAN OR PACIFIC ISLANDER WHITE OTHER

**ETHNICITY:** HISPANIC OR LATINO NON-HISPANIC OR LATINO

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# Attention Patients

We here at City Urgent Care, PC are focused on helping you (the patient) feel better, no matter the ailment. We feel it is important for you to know that we are strictly an urgent care. We do not operate as a Pain Management Clinic. For this reason, we do not routinely refill or prescribe narcotic pain medications. It is up to the provider seeing you to decide on the appropriate therapy for your condition. If this policy conflicts with your intended visit, we suggest you seek medical attention at an Emergency Room or follow up with your Primary Doctor or Pain Management specialist.

We appreciate your understanding and compliance. By signing this form, you agree to abide by our recommendations and fully understand our narcotics policy.

_____
Print Name

_____
Patient/Guardian Signature

_____
Date

# City Urgent Care
# Financial Disclosure and Consent Form

**Consent for diagnostic and therapeutic procedure:**

I hereby consent to and authorize a provider of City Urgent Care (CUC), and any other health professionals as designated, to perform a physical exam and diagnostic tests which are deemed medically necessary for my treatment. I also consent and authorize CUC providers to prescribe a therapeutic treatment plan, which I shall follow. Unless I explicitly refuse, I consent to diagnostic/invasive/therapeutic procedure(s) ordered by the CUC providers despite the risk involved and/or complications that may occur, which will be explained to me at the time the procedure(s) is/are ordered. By providing CUC with your primary doctor's name, we reserve the right to communicate with your primary physician regarding each encounter.

**Permit to submit medical claims:**

I request that payment of Medicare Benefits and other Insurance companies benefits be made on my behalf to CUC. I authorize the release of the medical information about me, which are necessary to process my claim, to the insurance companies with which I have coverage. I understand that it is my responsibility to provide complete and accurate information about my insurance(s) that I have. I authorize my insurance companies to release information about me that is related to my eligibility for benefits or coverage of specific services to CUC I understand that CUC agrees to accept the payment made by Medicare and/or other insurance companies as its full charge, I am only responsible for the deductible amount, co-pay or any amount for services not covered by my insurance.

**Financial Responsibility:**

This information is accurate and true to the best of my knowledge. I acknowledge and accept responsibility for payment of services rendered, including reasonable attorney's fees and costs of collection in the event of default. A $25 after hour fee applies to services rendered on weekends, holidays, and on weekdays after 5pm. I further understand that if a payment becomes 120 days past due, delinquency at the lesser of the annual rate of 26% or the maximum allowable rate will be due on delinquent amounts from the date the payment was due. In addition, each additional statement after the first statement will incur a $5 processing fee. Any debt that is over 365 days overdue will be charged a 40% collection agency fee which will be required to be paid by the owing patient.

_____ _____

**Patient Signature or Legal Representative** **Today's Date**

_____

**Print Name**

**If signed by legal representative, please state relationship to patient:** _____

**Name and address:** _____

_____

**Other Uses of Medical Information Require an Authorization:** Other uses and disclosures of medical information not covered by this Notice or the laws that apply to **City Urgent Care** will be made only with your written authorization. If you provide **City Urgent Care** an authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, **City Urgent Care** will no longer use or disclose medical information about you for the reasons covered by the written authorization. You understand that **City Urgent Care** is unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provide you.

**YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU**

You have many rights with regard to your medical information. If you wish to exercise any rights, you must submit your request in writing, unless otherwise noted.

**Your Right to Inspect and Copy:** You have the right to inspect and copy medical information that may be used to make decisions about your care. **City Urgent Care** may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

**Your Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to add a statement. You must provide a reason that supports your request for an amendment. Your right to an Accounting and Disclosures: You have the right to request an "accounting of disclosures." This is a list of certain disclosure **City Urgent Car**e made of medical information about you. Your request must state a time period. We may limit the time period to 6 years and to disclosures made after April 14, 2003. The first list you request within a 12-month period is free. For additional lists, we may charge you for the costs of providing the list.

**Your Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information **City Urgent Care** uses or discloses about you. For any services for which you paid out-of-pocket in full, we will honor any request you make to restrict information about those services from your health plan, provided that such release is not necessary for your treatment. In all other circumstances, we are not required by law not agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

**Your Right to Request Confidential Communication:** You have the right to request that **City Urgent Care** communicates with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. If we maintain medical information about you in electronic format, you also have the right to obtain a copy of such information in electronic format and to direct us to transmit such information directly to an entity or person clearly, conspicuously, and specifically designated by you. We will not ask you the reason for your request. You may make this request in writing or verbally.

**Right to Paper Copy of this Notice:** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Right to File a Complaint: If you believe your rights have been violated, you may file a complaint with us. You may also file a complaint directly with the Secretary of the Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

**Changes to This Notice:** **City Urgent Care** reserves the right to change this Notice. We reserve the right to make revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice at our offices and make copies available upon request.

**Privacy Notice Contact Information, City Urgent Care** is required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protect health information. If you have any objections to this form, please contact our office manager at (313)308-2444.

**Acknowledgement of Receipt of Notice of Privace Practices**

My signature below indicated that I have been provided witha Copy of HIPPA Notice of Privacy Practices

| | |
|---|---|
| **Patient or Legal Representative Signature** | **Today's Date** |
| **Print Patient Name** | **Patient Date of Birth** |