URGENT CARE OF THE SMOKIES

Patient Information

Patient Full Name			Date of Birth
Address			SS#
City	State	Zip	Gender
Email			Phone #

Emergency Contact

Name	Phone #	Relation

Responsible Party (Guarantor/ Parent)

Full Name			Date of Birth
Address			SS#
City	State	Zip	Gender
Email			Phone #

Financial Policy

Any applicable co-payment, co-insurance, and/ or deductible will be collected at the time of service. UCSmokies submits claims to all major medical insurances as a convenience to our patients. However, we request authorization to store a major credit/ debit card on your account to cover any remaining balance. This balance cannot be determined until your claim has been processed by your insurance. I authorize direct payment to UCSmokies and I understand my insurance will make the final determination as to the medical services covered. I understand the terms of payment and I have read UCSmokies Financial Policy. I understand and accept I am ultimately responsible for payment of services rendered by UCSmokies if such services are not covered by my insurance. A surcharge of 3% will be charged to cover the expense of merchant fees when using a credit card.

X_____ **Date**_____

Signature of Patient or Guarantor

Authorization & Release for all Medical Treatment

I voluntarily consent to the administration and cost of medical/ surgical procedures, x-ray, laboratory, and/ or medication for myself/ dependents. I authorize the release (verbal or written) of confidential medical information concerning myself / my dependent's health to any person or entity including my insurance, employer (EPS only), or ancillary services (LabCorp, Diatherix) which may be liable to me or my practitioner(s) for charges of this treatment and for quality management, utilization review, transfer, and follow-up purposes.

X_____ **Date**_____

Signature of Patient or Guarantor

Privacy Practices

The Health Insurance Portability & Accountability Act (HIPAA) requires UCSmokies to disclose our strict policies and procedures to protect your confidential health information. UCSmokies will not release a patient's confidential and/ or unauthorized information without written permission from the patient and only for the purposes of diagnosis and/ or treatment. A copy of this agreement may be used with the same effectiveness as the original.

X_____ **Date**_____

Signature of Patient or Guarantor

Insurance_____

Pharmacy (Circle One)

CVS	PUBLIX
FOOD CITY	WALMART
KROGER	WALGREEN'S

Name_____

Date of Birth_____

Drug Allergies_____
_____

Daily Prescription List_____
_____
_____
_____
_____

Past Medical History_____
_____
_____
_____

What are we seeing you here for today? (Please include *All Symptoms*)_____
_____

When did your symptoms begin?_____

Do you need a note or WORK/ SCHOOL?_____

Currently Pregnant/ Breastfeeding?_____

Up to date on vaccines?_____**Tetanus?**_____

Tobacco Use?_____**Alcohol Use?**_____

TRIAGE NOTES

Temperature_____

Pulse_____

Blood Pressure _____ **R L**

O2%_____

Weight_____

Height_____