SOUTHERN URGENT CARE

Patient Name:_____ **Date of Birth:** _____

Reason for Today's Visit:_____ **Symptoms Began:**_____

Gender: M F **Height:** _____ **Weight:** _____

Date of Last Menstrual Cycle: _____ Hysterectomy Menopausal Post-Menopause

Pregnancy: _____ weeks **Breastfeeding** Y N **Tetanus in Last 5 Years** Y N

Employed: Y N Retired Disabled Homemaker Student **Occupation:** _____

Smoke Y N FORMER If Yes: Occasionally Daily **Vape (e-cigarettes)** Y N

If Patient is a child, any smokers in the household? Y N

Drink Y N If Yes: Socially Daily (average drinks/day & type: _____)

Recreational Drugs Y N If Yes, which drug(s): _____

Drug Allergies & Reactions_____

_____

_____

Chronic Medical Conditions: _____

_____

_____

Surgeries: _____

_____

Family History (please circle if your parents have had any history of these diseases)

Diabetes Asthma Hypertension Cancer COPD Heart Attack Stroke Thyroid Disease Clots Anemia
Bleeding Seizures Kidney Disease Liver Disease CHF Psychiatric Illness Seizures Digestive Problems

Medications (name, milligram, # per day) _____

_____

_____

_____

Office Use Only: BP:_____ ***Pulse:***_____ ***Resp:***_____ ***Temp:***_____ ***Ox:***_____ ***Pain***_____

SOUTHERN URGENT CARE

Patient Name: _____

Date of Birth: _____/_____/_____ SSN# _____-_____-_____ Sex: M F

Mailing Address: _____

City: _____ State:_____ Zip: _____

Home #: (_____) _____-_____ Work #: (_____) _____-_____ Cell # : (_____) _____-_____

Email:_____

Responsible Party: _____

Relationship to Patient: _____

Primary Care Physician: _____

Do you have insurance? Y N (If yes, please give **ALL** insurance cards and your ID to front desk staff)

Emergency Contact Information

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code _____

Home Number: (_____) _____-_____ Cell Number: (_____) _____-_____

I authorize Southern Urgent Care to release any medical information required during the course of examination and treatment and permit payment directly to them any benefits due for services rendered. I recognize and accept responsibility for services rendered regardless of Insurance coverage. This includes but is not limited to Co-insurance, Co-payment, deductible and non-covered services. **I understand payment is expected at time of service.**

Signature of Responsible Party: _____ Date: _____/_____/_____

Southern Urgent Care 4717 Hwy 80 East Suite H-I Savannah, GA 31410
Phone (912) 898-2227 Fax (912) 898-2230 www.southernuc.com

Authorization to Treat

I authorize the physician and staff of Southern Urgent Care to treat me or the person for whom I have responsibility. I understand that this consent to treat includes my consent for medical test, procedures, drugs and other services and supplies as considered advisable; and may include, but is not necessarily limited to: anesthesia, pathology, radiology, and other imaging and diagnostic services, and other special tests and services including tests for communicable diseases and toxins, as ordered by the physician responsible for my care during my visit to Southern Urgent Care. I acknowledge that the practice of medicine is not an exact science and no guarantees or promises have been made to me as to the results of examination, care, or treatment at Southern Urgent Care. I acknowledge that it is important for me to provide accurate and complete information regarding my symptoms, medications, drug use, and other information, and that failure to do so can adversely impact my care.

I have been offered a copy of Southern Urgent Care's Notice of Privacy Practices to read and/or take home with me. I understand that if I want more information about these privacy practices or have questions or concerns, I may ask the center's staff or contact Southern Urgent Care as indicated on the notice.

I authorize Southern Urgent Care, or its agents, to release medical or other information to my insurance company, the Center for Medicare and Medicaid Services, or its carriers, as necessary to determine payment for these or related services. I request that payment authorized by my insurance company, the Center for Medicare and Medicaid Services, or its carriers, be made on my behalf to Southern Urgent Care for services provided by said group. I certify that any information I provide related to my eligibility for coverage or payment is accurate and complete. I understand that I am required to notify Southern Urgent Care of any change in insurance coverage.

I understand that payment is expected at time of service. I understand I am financially responsible for payments of services provided during the visit if I do not have insurance coverage or if I have coverage and timely payment is not made. I also understand that if I have a co-payment for this service, it is payable today. I may be charged an additional fee to cover the cost of billing the co-payment, if not paid today. I understand that I am responsible for paying the amount of any discount imposed if my insurance provider or third party payer imposes discount which are not authorized by a signed agreement between that payer and Southern Urgent Care.

Certain lab tests may be sent to an independent lab for processing. I understand I may receive a separate bill for these services. Southern Urgent Care utilizes PathGroup for all Send-Out labs unless otherwise requested by patient. Radiology services may result in an additional bill from the Radiologist from Carolina Radiology and any specialty orthopedic products will be billed by Meadows DME or Alliance Home Medical.

Some insurance companies require prior authorization for certain services. If I am required to obtain an authorization for today's visit and have not done so, I agree to assume all financial responsibility. If I receive any additional services from specialists, hospitals, or other healthcare providers in connection with or as a result of this visit, those charges may also be my responsibility, unless preauthorized as required by my insurance company.

In the event that collection procedures are initiated on any outstanding balance, I agree to be responsible for the costs of collection including, but not limited to: court costs, expenses, and attorney fees, to the extent permitted by law. I understand that the foregoing provisions apply equally to any individual for whom I am authorized to consent to treatment, or for whom I qualify as an authorized representative or authorized agent under any laws.

We cannot provide continued refills of controlled medications which include, but are not limited to Ativan, Xanax, Ambien, Klonopin, Hydrocodone, Tramadol & Tylenol with Codeine.

_____ **Date:** _____

Patient's Signature *If patient is unable to sign, write patient's name on the signature line above and have guardian/ representative sign below.

_____ **Date:** _____

Parent, Guardian or Representative Signature

Print Patient's Name _____ **Date of Birth** _____

Southern Urgent Care 4717 Hwy 80 East Suite H-I Savannah, GA 31410
Phone (912) 898-2227 Fax (912) 898-2230 www.southernuc.com