Westlake Village Urgent Care, Occupational and Family Medical Clinic, Inc

OFFICE POLICIES AND GENERAL CONSENT

Consent for Treatment

I hereby consent to and authorize administration of all diagnostic testing and treatment that may be considered advisable or necessary in the judgment of the attending physician/provider of the Westlake Village Urgent Care. I confirm that my stated medical history is accurate to my knowledge. I recognize that medicine is not an exact science and that my diagnosis and treatment may involve risks. Furthermore, I acknowledge that no guarantees have been made to me as the result of examinations or treatments.

Personal Valuables: I understand and agree that the facility shall not be liable for the loss of or damage to any of my personal property.

Financial Agreement: I, the undersigned agree, whether I sign as the parent/agent/guardian or as the patient, that in consideration of the services to be rendered to the patient, I hereby obligate myself to pay the account of the facility in accordance with the regular rates and terms of the facility. Should the account be referred to collection, I the undersigned, shall pay actual collection expense. There will be an additional charge of $25.00 added to any "bounced"/returned check.

The Westlake Village Urgent Care will bill and or assist you in billing any third-party payer. However, please understand that the balance in full is your responsibility. If your insurance carrier has not paid in thirty days, the balance will be turned to you/the patient and payment in full will be expected. It is the patient's responsibility to understand the extents and limitations of their own insurance policies.

All copays are due at the time of service. If we are an out of network provider or you do not have a third party payer, payment in full is expected at the time of service.

Assignment of Benefits: I, the undersigned, authorize, whether I sign as an agent or as the patient, direct payment to the facility of any insurance benefits otherwise payable to me for this office visit. I request payment of authorized benefits directly to Westlake Village Urgent Care for services furnished to me at this facility. I consent to the release of medical and other information related to such services for healthcare operations and to Medicare, my insurance company, HMO, other third party payers, or their third party administrators, in order to process and pay claims, determine benefits and perform quality of care reviews.

HIPPA Notice of Privacy Practices

I have been provided with the 2 page document titled "HIPPA Notice of Privacy Practices" and agree to those terms. I understand that I may request a hard copy of this document at any time or download it from our website at www.westlakevillageurgentcare.com

Contact Mechanism

Urgent Care Staff may mail, email, TEXT or leave a detailed voice message for me regarding Test Results, Follow-up, Billing etc at the numbers and addresses below.

_____ _____/_____/_____

Patient Name- Please Print Date of Birth

Address_____City_____State_____ZIP_____

Mobile Phone (_____) - _____ - _____ Email:_____@_____

_____ _____/_____/_____

Signature of patient or authorized representative Today's Date

Emergency Contact (Name & Phone #)_____

Westlake Village Urgent Care HEALTH HISTORY FORM

Name: _____ **Age** _____ **M / F** **Date:** ___/___/

WHY ARE YOU HERE TODAY? (Mark/ circle all that apply) or **Other (Please explain):** _____

PAIN: *Chest Back Neck Abdomen Ribs Ear(s) Eye(s) Face Headache Bone Injury Other pain:*_____
"Cold/ Flu" symptoms: *Hard to Breathe Fever Chills Sore Throat Body Aches Runny nose Sinus congestion Cough Wheeze*
GI/GU: *diarrhea nausea vomiting constipation heartburn urinary pain/ frequency (UTI) gynecological concern*
Misc: *palpitations swelling/edema dizziness numbness weakness fatigue anxiety depression insomnia vision change rash/skin problem allergic reaction* _____
WELL VISIT: ***Physical (work/ sports) Labs/ Shots/ B-12 STD screening TB screening***

Please list or attach all Medications including dose and how often you take them (Prescription and Over-the-Counter)

_____ _____ _____

_____ _____ _____

_____ _____ _____

List **Medication Allergies:** _____ **Environmental Allergies:** (Latex, tape, pollen, etc) _____

YOUR PAST MEDICAL HISTORY (Check all that apply)

Anemia	□ Yes	□ No	Anxiety	□ Yes	□ No	Asthma	□ Yes	□ No
Blood Clots	□ Yes	□ No	Depression	□ Yes	□ No	Diabetes	□ Yes	□ No
Eating Disorder	□ Yes	□ No	Epilepsy/Seizure	□ Yes	□ No	Heart Disease	□ Yes	□ No
Head Injury/Concussion	□ Yes	□ No	Hearing Problems	□ Yes	□ No	High Cholesterol	□ Yes	□ No
Heart Murmurs	□ Yes	□ No	High Blood Pressure	□ Yes	□ No	Liver Disease	□ Yes	□ No
Hepatitis	□ Yes	□ No	Kidney Disease	□ Yes	□ No	Thyroid Disease	□ Yes	□ No
Migraines	□ Yes	□ No	Urinary Tract Infection	□ Yes	□ No	Vision Problems	□ Yes	□ No
Surgeries	□ Yes	□ No	List:					
Hospitalized	□ Yes	□ No	Explain					

Recently travelled outside the US? □ No □ Yes: Where? _____ When? _____

SOCIAL HISTORY

Tobacco Use	□ No	□ Yes: Packs/Chew/Vaping per day? Per Week? How many years?
Alcohol Use	□ No	□ Yes : 1-5 per year_____ 1-5 per week_____ 1-2 per day_____ More than 2 per day_____
Drug Use	□ No	□ Yes: List: Marijuana □ Yes □ No
Exercise	□ No	□ Yes: How many days a week?

FAMILY HISTORY (Mark all that apply for blood relatives ie: parents ,grandparents, siblings)

□Heart disease	□Stroke	□ Kidney disease	□Asthma	□ Anxiety	□ Cancer
□High Blood Pressure	□Diabetes	□ Liver Disease	□Migraines	□ Depression	□

FEMALE HISTORY

Are you Pregnant?	□ Yes	□ No	Last menstrual period?____/____/_____	Birth control used?
Date of last Pap smear:			Do you have a history of abnormal Pap smears?	Date:

CHILDREN'S HISTORY

Are immunizations up to date?	□ Yes	□ No	Normal development?	□ Yes	□ No Explain:
Does anyone in the home smoke?	□ Yes	□ No	Animals in the house?	□ Yes	(Circle) Dog, Cat, Bird, Rodents, Reptiles

SIGNATURE: _____ **DATE:** _____