WELCOME TO PRONTO MEDICAL CARE!

PLEASE READ OVER AND FILL OUT ALL SECTIONS OF THE NEW PATIENT PAPERWORK.

THIS MEDICAL CLINIC DOES NOT PRESCRIBE CONTROLLED SUBSTANCES FOR CHRONIC CONDITIONS.

IF YOU HAVE A MEDICAL PROBLEM, CHECK IN. PLEASE DO NOT TRY TO RESOLVE MEDICAL CONDITIONS OR SYMPTOMS OVER THE PHONE OR WITH THE FRONT DESK.
WE WILL DO OUR BEST TO HELP YOU.

FOR SAFETY REASONS, IF YOU NEED REFILLS ON MEDICATIONS WE HAVE PRESCRIBED. PLEASE NOTIFY YOUR PHARMACY TO SEND US A REFILL REQUEST. TURN AROUND TIME IS (24-72HRS) FOR US TO RESPOND.

PRINTED NAME	SIGNATURE	DATE
WITNESS	DATE	

Patient's Information

Patient's Name: (First)_____(Last)_____(M.I)_____

Address:_____

City, State: _____ZIP CODE: _____ Sex: Female Male

Date Of Birth:_____ Email Address:_____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Are you Single/Married/Divorced/Widowed/Separated? _____

Race: American Indian/ Alaskan Native/ Asian/ Native Hawaiian/ Pacific Islander/ African American/ White/ Declined
Ethnicity: Hispanic/Latino Not Hispanic/Latino Decline Language: English Spanish Other: _____

Parent or Guardian (For Minor Child)

Name: (Last)_____(First): _____

Phone Number: _____

Emergency Contact

Name: (Last)_____(First): _____

Home Phone: _____ Mobile Phone: _____

Relationship to Patient: _____

Insurance

Primary
Insurance Company: _____ Policy Number: _____

Name of Insured: _____ Insured's DOB: _____

Patient Relation:_____ Group ID:_____

Secondary
Insurance Company: _____ Policy Number: _____

Name of Insured: _____ Insured's DOB: _____

Patient Relation:_____ Group ID:_____

How did you hear/Who referred you to our clinic? _____

Consent for Treatment and Payment Agreement

I hereby authorize Pronto Medical Care and its Providers to use/or disclose my healthcare information which specifically identifies me, to carry out my treatment, payment, and healthcare operations.

Treatment includes but not limited to: the administration and performance of all treatments and anesthetics, the use of prescribed medications, the performance of such procedures that may be deemed necessary or advisable such as diagnostic procedures, injections, taking/utilizing cultures or other laboratory testing, all in which are the judgement of the attending physician or assigned designees may be considered medically necessary.

Payments include but are not limited to: the authorization of payment directly to Pronto Medical Care and its providers. I hereby acknowledge the release of my medical records to third party insurers and authorized persons to whom disclosure is necessary to establish a fee for services provided. Including billing and collection services, insurance payers, auto accident insures, work related injuries, and all general medical practicing. I understand that I am financially responsible for charges not covered by my insurance/self-pay pricing.

Healthcare operations are authorized to release my medical healthcare information to other physicians/medical offices/insurance companies that are participating in my care/treatment.

I understand that this is given in advance to any specific diagnosis or treatment. I acknowledge that I am here voluntarily and have the right to refuse services. I intent for this consent to be continuing in nature even after a diagnosis has been made and treatment recommended. This consent will remain in force unless revoked in writing and will not affect the actions taken prior to receiving the revocation. A photocopy of this consent is as valid as the original.

Patients are responsible for all charges accrued. It is courtesy of the office to file with your insurance company. However, you are responsible for your co-pays, percentages of deductibles and co-insurance rates at the time of your visit and after claims processed. It is the patient's responsibility to provide us with the most updated insurance information, addresses and phone numbers. Insurance premiums must be up to date, if your premium payments are not up to date you may be responsible for rejected claims amount, or full payment at the time of service. Insurance Companies/Marketplace Plans/Medicare have timely filing limits for all claims ranging 60 days to 6 months. If outside of the filing limit, we can not go back and reprocess claims.

I have fully read and understand the above statements and agree to the conditions of the policy.

Initial:_____

Printed Name:_____ **Date:**_____

Signature:_____

HIPPA Acknowledgement and Consent Form

I understand that **Pronto Medical Care** originates and maintains paper/electronic records describing my health history, symptoms, examination findings, medical diagnoses, treatment plans, testing results, and any plans for future care.

I understand and have been provided with a Notice of Privacy Practices that provides a more completed description of information and disclosures. I understand I have the following rights:

The right to review the notice prior to signing this consent.
The right to object to the use of my healthcare information for directory purposed.
The right to request restrictions as to how my health care information may be used.

I understand that **Pronto Medical Care** is not required to agree with my restrictions requested and refuse services. I may revoke this consent in writing, except to the extent that the organization has already acted in reliance thereon. I Acknowledge that by refusing to sign this form or revoking the consent **Pronto Medical Care** and its providers may refuse treatment as permitted by **Section 164.506 of the Code of Federal Regulations.**

I acknowledge that as part of my treatment and healthcare operations it may be deemed necessary to disclose my healthcare information to another entity and I consent to such disclosure for these permitted uses including by fax, electronic recording, and paper record. I accept and understand the terms of this consent.

Printed Name:_____ **Date:**_____

Signature:_____

Disclosure to Family Members/Designated Guardians

I give permission for **Pronto Medical Care and its providers** to release my healthcare information, discuss my related care, any medical conditions, results, findings and care decisions with the following listed below. I understand that whoever I list will have access to my healthcare information.

Full Name	Relationship	Phone Number

PATIENT'S MEDICAL HISTORY

Patient's Name:_____D.O.B_____

What are you coming in for today? _____

Signs/Symptoms: _____

CIRCLE ANY PREVIOUS/CURRENT MEDICAL CONDITIONS LISTED BELOW

HEADACHES	MIGRAINE HEADACHES	OSTEOPOROSIS	GLAUCOMA
COLLAGEN VASCULAR DISEASE	HIGH BLOOD PRESSURE	EPILEPSY	HEMORRHOIDS
CHRONIC SINUS INFECTION	DIABETES	RED MEASLES	BRONCHITIS
COPD	MUMPS	SCARLET FEVER	THYROID DISEASE
CARPAL TUNEL	RHEUMATIC FEVER	ASTHMA	MITRAL VALVE PROLAPSE
SEIZURES, CONVULSIONS	POLIO	LUPUS	PERSISTENT COUGH
KIDNEY DISEASE	ENCEPHALITIS	HIV/AIDS	FIBROMYALGIA
RHEUMATOID ARTHRITIS	TUBERCULOSIS	PSYCHOSIS	OBESITY
GAIT ABNORMALITY	HIATAL HERNIA	POLYMYOSITIS	HEART DISEASE
ALCOHOLISM	PNEUMONIA	SHINGLES	HEART ATTACK
TRIGEMINAL NEURALGIA	SUBSTANCE ABUSE	CHRONIC BACK PAIN	ULCER
DEPRESSION/ANXIETY	CHRONIC NECK PAIN	BIPOLAR	STROKE
REITERS DISEASE	CROHN'S DISEASE	AMNESIA	CHICKEN POX
HEPATITIS	CANCER_____	BLADDER INFECTIONS	OTHER: _____
	STD'S	HPV	_____

Any Surgical History: **Yes or No** If yes, please list:_____

_____

Any Known Drug Allergies? **Yes or No** If yes, please list:_____

_____

Family History: **Adopted** **No Known Family History** **Please list any known conditions:**_____

_____

PLEASE CIRCLE YOUR ANSWER

USE OF ALCOHOL: NEVER RARELY MODERATE DAILY

USE OF TABACCO: NEVER PREVIOUSLY BUT QUIT(YEAR)_____ CURRENT PACKS PER DAY _____

USE OF DRUGS: YES OR NO IF YES, PLEASE LIST TYPE: _____

If you take any medications, please list:_____

_____