Valley Urgent Care
& OCCUPATIONAL MEDICINE

Valley Urgent Care & Occupational Medicine
1921 Medical Ave, Suite A
Harrisonburg, VA 22801
Phone: 540-434-5709
Fax: 540-434-5710

Work Related Injury? ☐ Yes ☐ No

PATIENT INFORMATION

Last Name _____ First Name _____ M_____

Date of Birth _____/_____/_____ Age _____ Sex at Birth ☐ M ☐ F Gender Identity _____

Social Security # _____ - _____ - _____ Email _____

Address _____ Apt # _____ City _____ State _____ Zip _____

Home Phone (_____)_____ - _____ Mobile Phone (_____)_____ - _____ Contact Preference? ☐ Email ☐ Cell ☐ Home ☐ Text

Race _____ Ethnicity _____ Preferred Language _____

Primary Care Physician _____ Phone (_____) _____ - _____

In case of Emergency (Name, Phone, Relation) _____

PARENT/GUARANTOR INFORMATION (IF MINOR)

Last Name _____ First Name _____ M_____

Date of Birth _____/_____/_____ Age _____ Sex ☐ M ☐ F Social Security # _____ - _____ - _____

Address _____ Apt # _____ City _____ State _____ Zip _____

Home Phone (_____)_____ - _____ Mobile Phone (_____)_____ - _____ Contact Preference? ☐ Email ☐ Cell ☐ Home ☐ Text

Relation to Patient _____

INSURANCE INFORMATION

Primary Insurance:

Company: _____

Policy Number: _____

Policy Holder: _____

Policy Holder DOB: _____

Relationship to Policy Holder: _____

Secondary Insurance:

Company: _____

Policy Number: _____

Policy Holder: _____

Policy Holder DOB: _____

Relationship to Policy Holder: _____

Receipt of Privacy Practices: By signing this consent form, I acknowledge that a copy of the Notice of Privacy Practices of Valley Urgent Care is available to me upon request. I understand that a copy of this consent form may be used with the same effectiveness as the original.

Patient / Guarantor Signature _____ Date _____

Patient History Form

Date: _____

Name: _____ DOB: _____ Age: _____ Sex: *M F*

Reason for visit / symptoms:

Social History *(Circle one)*

Tobacco use: N Y If yes, how many packs per day _____ Vape: N Y Alcohol: N Y If yes, how often? _____

Allergies (Drug / Food / Environmental):

Allergy *Reaction*

Current Medications

Please list any medications that you are now taking. Include non-prescription medications & vitamins/supplements:

Name of drug *Dose (include strength & number of pills per day)* *How long have you been taking this?*

1. _____
2. _____
3. _____
4. _____
5. _____

Past Medical History

Do you now or have you ever had:

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High cholesterol
- ☐ Hypothyroidism
- ☐ Epilepsy
- ☐ GI Disorder _____
- ☐ Goiter
- ☐ Cancer (type) _____
- ☐ Leukemia
- ☐ Skin Disorders
- ☐ Vision disorder _____
- ☐ Emphysema
- ☐ Heart problems _____
- ☐ Asthma
- ☐ Blood disorder _____
- ☐ Stroke
- ☐ Kidney disease _____
- ☐ Liver Disease

Other Medical Conditions: _____

_____

Surgical History: _____

_____

Family Medical Problems (Past and Present):

Mother: **Siblings:**

Father:

Patient/Guarantor Signature: _____ Date: _____

Financial Responsibility

Patient Name: _____ DOB: _____

At Valley Urgent Care, we are committed to providing you with the best possible care. Please help us serve you by allowing us to focus on patient care and reducing the number of bills we must send to you.

Payment is expected at the time of service: You will be asked to pay your co-pay, deducible, and any outstanding balance at the time of your appointment. Please arrive prepared to take care of these financial matters. Valley Urgent Care accepts cash, personal check, VISA, MasterCard, AMEX, Discover.

Out-of-Network/Self-Pay: There are many insurance choices, and we may not participate with your plan. We will courtesy file your insurance claim and charge a $50 out-of-network fee at the time of visit. However, self-pay patients are expected to pay their bill at the time of service. While we try to obtain all the medical charges prior to check out, there may be corrections to your statement when the medical notes are finalized by the doctor. If there is an outstanding balance after your date-of-service payment, you will be billed for that amount. If you overpaid, you will be refunded accordingly.

Insurance: Please check with your insurance carrier prior to making your appointment to look over your benefits and responsibilities. Every plan is different, and insurance is not a guarantee of payment. The patient or guarantors are ultimately responsible for payment of service rendered.

We will submit your bill to our participating insurance companies as a courtesy to you. Is it your responsibility to make sure we have accurate insurance and billing information. If a claim is unsuccessful because of a flawed insurance or billing information, you will be responsible for the balance. Please be sure that we are aware of any restrictions of your policy has on ancillary services (such as requiring a specific lab). We will bill secondary insurance companies if you have provided that information AT THE TIME OF YOUR VISIT.

If we are unable to verify your insurance at the time of your visit, or you do not have your insurance with you, full payment is due prior to service.

If your insurance has a co-payment policy, the co-payment is due at the time of service. If you have a deductible, you may be responsible for all charges until the deductible is met. You are responsible for any and all remaining balances after your insurance has paid its portion.

If we do not receive payment from your insurance within 60 days of the date of service, you may be expected to pay the balance in full. When you receive a statement, you will have 30 days to remit any additional balances due, unless a payment arrangement has been extended to you. Outstanding balances not paid in full within 60 days of the original invoice may be turned over to collections. If your account becomes assigned to a collection agency, you agree to pay a 40% collection fee, interest in the amount of 18% APR, court costs, and attorney fees. Please contact us immediately in order to avoid potential collections.

It is your responsibility to make sure we have a way to contact you with billing or scheduling issues. Should we receive return mail, we will try the phone number listed in your file. If we are unable to contact you, your account may be sent to collections.

Communications with you – TCPA: You agree that in order for us to service our account or to collect any amount you may owe, we, our agents, assignees, and third party(s) or servicing agent(s) may contact you by phone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Methods of contact may include using pre-recorded/artificial voice messages, automatic dialing devices and/or text messages, as applicable. You agree that we, our agent, assignees, third party(s) or servicing agent(s) may, for training purposes or to

evaluate the quality of service, listen to a record phone conversation you have with us and/or our agents, assignees, third party(s) or servicing agent(s)

Returned checks/refunds: Valley Urgent care charges a $50 fee, IN ADDITION WITH OUR BANK FEES, for any returned checks.

Patient/guarantor credits in amounts less than $5.00 will be retained on the account to be credited toward future balances unless written request for refund is received. Amounts of $5.00 and greater will automatically be refunded to the patient/guarantor.

Forms for other forms of insurance/disability claims, etc.: We charge a $25 fee for each supplemental form that you request we fill out for you. This includes, but not limited to, supplemental insurance (i.e. life insurance, AFLAC), short/long term disability claim forms, FMLA forms, physician's statements, and medical leave forms. This fee must be paid at the time the forms are dropped off. Forms cannot be completed until the fee is paid in full.

Print Name: _____

Signature: _____

Date: _____

Consent for Treatment and Payment

I give my consent to Valley Urgent Care and Occupational Medicine ("VUC") to provide clinical services needed by me, including any procedures and treatments deemed necessary for my best health and wellness. I understand that VUC will explain treatments and procedures to me. I further understand that this consent shall remain in effect until it is retracted in writing to VUC.

I agree that for VUC to service their account or to collect any amount I may owe, they, their agents, assignees, and third party(s) or servicing agent(s) may contact me by phone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Methods of contact may include using pre-recorded/artificial voice messages, automatic dialing devices and/or text messages, as applicable. I agree that they, their agent, assignees, third party(s) or servicing agent(s) may, for training purposes or to evaluate the quality of service, listen to a record phone conversation I have with VUC and/or their agents, assignees, third party(s) or servicing agent(s).

I hereby authorize payment directly to VUC for all medical benefits available to me. I understand that if my insurance coverage does not cover the services rendered, the services will be billed to me directly. If my account becomes assigned to a collection agency, I agree to pay – in addition to the balance – a 40% collection fee, interest in the amount of 18% APR, court cost and attorney fees.

A photocopy of this agreement is to be considered as valid as an original authorization.

Patient Name: _____

Signature: _____

Relationship to patient: _____

Date: _____

Release of Information

Patient Name: _____ D.O.B: _____

I authorize any staff with Valley Urgent Care to disclose my protected health information ("PHI") to the party or parties below:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Patient Signature: _____

Date: _____