# New Patient Registration Form

Arrival Time:_____ Today's Date _____

## PATIENT INFORMATION

Patient Name:_____ Date of Birth:_____ Sex: _____

Purpose of visit/chief complaint: _____

Drug Allergies: _____

Home Phone: _____ Cell Phone: _____ Primary Email _____

Mailing Address:_____ City: _____ State: _____ Zip:_____

Primary Care Physician: _____ PCP Phone #: _____

Pharmacy Name _____ Address_____ Phone _____

Race: Undefined / American Indian or Alaskan Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander / Caucasian

Ethnicity: Non Hispanic / Hispanic / Declined to Report Language preference: English / Spanish / Other _____

### Father

Name: _____DOB_____

Address (If different): _____
City: _____State: _____ Zip:_____

Home Phone (If different): _____
Email: _____

Occupation_____

Employer_____

### Mother

Name: _____DOB_____

Address (If different): _____
City: _____State: _____ Zip:_____

Home Phone (If different): _____
Email: _____

Occupation_____

Employer_____

Legal Guardian: Both Parents ___ Mother ___ Father ___ Other _____

## ACCOMPANYING ADULT

Accompanying Adult Name:_____ Relationship to Patient:_____

Address (if different from Patient)_____ City: _____ State: ____ Zip:_____

Home Phone: _____ Work Phone: _____ Email: _____

### Insurance Information

Insurance Policyholder Name: _____

Relationship to Patient: _____

DOB: _____

Insurance Company: _____
Phone: _____

Address: _____

City: _____ State: _____ Zip:_____

Policy Holder ID#: _____

Group #: _____

Plan #:_____

Employer Name: _____

### Emergency Contacts

Name: _____

Relationship to Patient: _____

Phone: _____

May this person seek medical care for your child? YES /NO

Name: _____

Relationship to Patient: _____

Phone: _____

May this person seek medical care for your child? YES /NO

## REFERRAL INFORMATION

I was referred to Your Kid's Urgent Care by: _____

How did you learn about Your Kid's Urgent Care:_____

# Forma de Resgistracion de Nuevo Paciente

Hora de llegada: _____ Fecha de Hoy: _____

## INFORMACIÓN DE PACIENTE

Nombre de Paciente: _____ Fecha de Nacimiento: _____ Sexo: _____

Propósito de visita/ Preocupación primaria: _____

Alergias de Medicamentos: _____

Numero de Hogar: _____ Numero de celular: _____

Correo electrónico primario: _____

Dirección Primaria: _____ Ciudad: _____ Estado: _____ Código Postal: _____

Doctor Primario: _____ Numero Telefónico: _____

Nombre de Farmacia: _____ Dirección: _____

Numero Telefónico: _____

Raza: Undefined / American Indian or Alaskan Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander / Caucasian

Etnicidad: Non Hispanic / Hispanic / Declined to Report Idioma Primario: English / Spanish / Other _____

### Padre

Nombre:_____

Fecha de Nacimiento _____

Dirección ( Si es diferente) _____

Ciudad: _____ Estado: _____ Codigo Postal: _____

Numero de hogar ( si es diferente) _____

Correo electrónico primario: _____

Ocupacion:_____

Empleador:_____

### Madre

Nombre:_____

Fecha de Nacimiento _____

Dirección ( Si es diferente) _____

Ciudad: _____ Estado: _____ Codigo Postal: _____

Numero de hogar ( si es diferente) _____

Correo electrónico primario: _____

Ocupacion:_____

Empleador:_____

Guardián Legal: Ambos Padres ___ Madre ___ Padre ___ Otro _____

## ADULTO ACOMPAÑANTE

Nombre del Adulto Acompañante: _____ Relación al Pacientes: _____

Direccion( si es diferente): _____ Ciudad: _____ Estado: ____ Codigo Postal: _____

Numero Telefónico: _____ Numero del Trabajo: _____

Correo electrónico: _____

### Información de Seguro Medico

Nombre del Primario del seguro: _____

Relación al paciente: _____

Fecha de Nacimiento: _____

Compañía de Seguro: _____

Numero telefónico : _____

Dirección _____

Ciudad: _____Estado: _____ Codigo Postal:_____

Numero de Identificación: _____

Grupo: _____

Plan: _____

Nombre de Empleador: _____

### Contacto de Emergencia

Nombre: _____

Relacion al patiente: _____

Numero Telefonico: _____

Puede esta persona buscar tratamiento medico por su Hijo?
Si / No

Nombre: _____

Relacion al patiente: _____

Numero Telefonico: _____

Puede esta persona buscar tratamiento medico por su Hijo?
Si / No

## INFORMACIÓN DE REFERIDO

Yo fui referido a Your Kid's Urgent Care por: _____

Como aprendió sobre Your Kid's Urgent Care? _____

# Authorized Consent to Seek Medical Care & Release

**I am providing my current insurance information along with my copayment or full payment for the services rendered.**

I also understand if Your Kid's Urgent Care is unable to obtain payment from my insurance company I am responsible for payment in full for services rendered to my child/children while under the care of the above named person.

**Copay must be paid by the authorized adult bringing the child in for services.

**For patients 16 years and older ONLY.** Patient listed below may present and be treated unaccompanied by an adult.

Yes _____ No _____ (parent please initial one)

☐ I do NOT authorize anyone other than the parents stated on the New Patient Paperwork to seek medical care for my child. (only mom or dad may bring patient to the office)

_____ ___/____/____
Parent/Legal Guardian Signature Date

**If you are allowing someone other than the parents to bring in the child (grandparents, nanny, aunt/uncle, etc. or in case parents are at work or out of town), please complete and sign below.**

I (parent/legal guardian), _____ am hereby giving permission for the following person to bring my child/children to Your Kid's Urgent Care and to receive medical treatment and advise during my absence.

Name _____ DOB _____ Relationship _____

Name _____ DOB _____ Relationship _____

Name _____ DOB _____ Relationship _____

Please specify dates: From _____ to _____ (ex. 18th birthday or a week you will be out of town and child will be in the care of someone else)

We will continue to rely on the information on this form unless you request changes. It is your responsibility to immediately notify Your Kid's Urgent Care of a divorce, legal separation, change in custody arrangement, or any other circumstance which may alter this authorization.

## CONSENT & RELEASE

**CONSENT TO TREATMENT:** I understand that medical treatment of an urgent nature is necessary for the patient and that such medical care, treatment and procedures will be performed by physicians and non-physician employees of Your Kid's Urgent Care during normal operating hours . I understand that medical treatment only is being provided, and that no responsibility will be taken for long-term patient care or care after normal hours of operation. I hereby grant my authorization and consent for such treatment and procedures, and certify that no guarantee of assurance has been made as to the results which may be obtained.

**AUTHORIZATION FOR PROMOTIONS:** I authorize Your Kid's Urgent Care to use my written comments, my name, and my photographs for promotional purposes. **( Y / N ) Initial:** _____

**ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY:** I hereby assign all medical and/or surgical benefits to which I am entitled, including government sponsored programs, private insurance and other healthy plans to Your Kid's Urgent Care. This assignment shall remain in effect until revoked by me in writing. I hereby authorize said Assignee to release all information necessary to secure the payment which is to be issued directly to Your Kid's Urgent Care for their services as described herein. I understand that I am financially responsible for all charges whether or not paid by said insurance. I promise to pay Your Kid's Urgent Care all charges, copayments, deductibles and coinsurance amounts for services rendered to or on behalf of the patient at the time of service. I further agree to pay all collection costs and attorney fees should the account become delinquent and be referred to a collection agency.

*I certify that all information is correct and the insurance is in effect as of today. I have read the above policy and agree to pay for all services not covered by my insurance. I understand that it is my responsibility to verify and know my insurance policy and my PCP. I authorize Your Kid's Urgent Care to request/release any medical information from or to another physician or medical institution as necessary for my medical care or filing purposes.*

**OUT OF NETWORK PLANS ONLY:** I understand that Your Kid's Urgent Care will file my insurance claims for services rendered to the patient as an out-of network or non-contracted provider. I understand that I will be financially responsible for all applicable non-paid charges. **Initial:** _____

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

_____ _____/_____/_____
**Parent/Legal Guardian Signature** **Date**

# Autorización de Consentimiento de atención Medica

**Estoy proveyendo mi información actual de seguro medico, con la información de co-pago o pago complete de servicio proporcionado hoy.**

Entiendo que si Your Kid's Urgent Care es incapaz de obtener pago de mi compañía de seguro medico seré responsable por pago en completo por el sevicio proporcionado a mi hijo/a bajo el cuidado por la persona mencionado arriba.

** El co-pago tiene que pagarse por el adulto autorizado que trae el paciente por tratamiento

**Para paciente de 16 años y mayores SOLAMENTE.** El paciente mencionado al debajo puede estar precente y obtener tratamiento sin un adulto precente

Si _____ No _____ (iniciales del padre)

☐ Yo NO autorizo a nadie fuera de los padres a que pueda traer al paciente para tratamiento medico para mi hijo/a ( Solamente Madre o Padre puede traer paciente a la oficina)

_____ ____/____/____
Firma de Padre/ Guardián legal Fecha

**Si va a dar permiso para que alguien que traiga a su hijo/a ( Abuelos, Niñera, Tía/Tío, etc. en caso de que los padres estén en el trabajo o fuera de la ciudad) por favor de completar y firmar.**

Yo ( Padre/ guardián Legal), _____estoy dando permiso para que las siguiente persona/s puedan traer a mi hijo/a a Your Kid's Urgent Care y recibir tratamiento medico y consejo en mi ausencia.

Nombre _____ Fecha de Nacimiento _____

Relación _____

Nombre _____ Fecha de Nacimiento _____

Relación _____

Nombre _____ Fecha de Nacimiento _____

Relación _____

Por Favor de especificar fechas: De Hasta ( ejemplo: cumpleaños de 18 años o la semana que usted este fuera de la ciudad y el cuidado del paciente sea otra persona)

Continuaremos usando la información dada hasta que se pido un cambio. Es su responsabilidad de notificar a Your Kid's Urgent Care si hay un divorcio, separación legal, cambio de arreglo de custodia, or otras circunstancia el las cuales se necesite cambiar esta autorización.

## CONSENTIMIENTO

**CONSENTIMIENTO DE TRATAMIENTO:** Yo entiendo que el tratamiento medico de Your Kid's Urgent Care es necesario para el paciente y que tales tratamientos y procedimientos médicos van a ser provisto por médicos y no médicos empleados por Your Kid's Urgent Care durante horas normales de operación. Yo entiendo que el tratamiento medico es solamente dado, responsabilidad por el paciente de largo plazo o tratamiento dado después de horas de operazion no va a ser de la oficina. Yo doy mi autorización y mi consentimiento para tratamiento y procedimientos, y certifico que no hay garantía de los resultados que se pueden obtener.

**AUTORIZACIÓN PARA PROMOCIONES:** Yo autorizo a Your Kid's Urgent Care que use mis comentarios escritos, mi nombre, y mi fotografías para propósitos de promociones. ( S/N) **Inicial:** _____

**ASIGNACIÓN DE BENEFICIOS Y RESPONSABILIDAD FINANCIERA:** Yo asigno todos mis beneficios médicos y/o quirúrgicos a los cuales tengo derecho, inclugendo programas dado por el gobierno, seguranca privada, y otros planes de salud a Your Kid's Urgent Care. Esta asignación debe mantenerse hasta que yo revoque en escrito el derecho. Yo autorizo que el asignado de toda la información necesaria para asegurar el pago que debería dar se a Your Kid's Urgent care por su servicio como descrito dentro. Yo entiendo que seré responsable financieramente por todos los cargos sea que el seguro pague o no. Yo le prometo a Your Kid's Urgent Care pagar todos los cargos, co-pagos, deductibles, y co-seguro por los servicios dado a o por el paciente durante el tiempo de servicio. Yo continuo en acuerdo a pagar los costos de colección y de abogado si los cargos no son pagados y son referidos a una agencia de colección.

*Yo certifico que toda la información dada es correcta y que el seguro esta en efecto desde hoy. E leído la policía y estoy en acuerdo en pagar todo los servicios que no estén cubiertos por mi seguro. Yo entiendo mi responsabilidad de verificar y conocer mi seguro y doctor primario. Yo autorizo a Your Kid's Urgent Care pedir/dar cualquier información medica de o a otro doctor o institución medica necesaria para mi tratamiento medico o para propósitos de archivos.*

**PLANES FUERA DE COBERTURA SOLAMENTE:** Yo entiendo que Your Kid's Urgent Care va a mandar reclamos por los servicios dado al paciente como un proveedor fuera de cobertura o un proveedor n o contratado. Yo entiendo que soy responsable financieramente por los cargos no pago por el seguro medico. **Iniciales:** _____

_____ _____/_____/_____
**Nombre del paciente** **Fecha de nacimiento del**

_____ _____/_____/_____
**Firma de Padre /Guardian Legal** **Fecha**

Your Kid's URGENT CARE

# Child Health History

**Date:** _____

| Patient Name: | M: ☐ F: ☐ | DOB: |
|---|---|---|

## ALLERGIES

DRUG: _____

FOOD: _____

OTHER: _____

## MEDICATIONS

PRESCRIPTION: _____

OVER THE COUNTER: _____

_____

## PRENATAL HISTORY

Illness during pregnancy: Y ☐ N ☐

Birth Weight: _____

Type of Delivery: _____

Complications: _____

Full Term: Y ☐ N ☐

Premature: Y ☐ N ☐

## GROWTH AND DEVELOPMENT

Normal:

If abnormal, please explain: _____

_____

_____

_____

_____

## PAST HISTORY (Check all that apply)

___ Recurrent Ear Infections
___ Hearing Loss
___ Chicken Pox
___ Blood Disorders
___ Depression
___ Seizures
___ Allergies
___ HIV/AIDS
___ Frequent Colds
___ Frequent Sore Throats
___ Tonsillitis
___ Lead Poisoning
___ Eating Disorders
___ Learning Problems
___ Alcohol/Drug Problems
___ Asthma/Bronchitis
___ Urinary Tract Infections
___ Sickle Cell Anemia
___ Headaches/Migraines
___ Developmental Delays
___ Bed Wetting
___ Tuberculosis
___ Stomach Problems
___ Heart Murmur
___ Mental Health Disorder

Immunizations up to date: Y ☐ N ☐

Injuries: _____

Surgeries: _____

Hospitalizations: _____

## SOCIAL HISTORY

Primary Language: _____ Grade in School: _____ Performance: _____

## FAMILY HISTORY (Check all that apply)

___ Asthma
___ Blood Disorder/Anemia
___ High Blood Pressure
___ Seizures
___ Heart Disease
___ HIV/AIDS
___ Sickle Cell Anemia
___ Heart Murmur
___ Mental Health Disorder
___ Kidney Disease
___ Birth Defects
___ Alcohol/Drug Problems
___ Cancer
___ Headaches/Migraines
___ Diabetes
___ Thyroid Disease
___ Tuberculosis
___ Sudden Infant Death Syndrome

**COMPLETED BY:** _____ **ARNP/PHYSICIAN:** _____

Your Kid's URGENT CARE

# Historia de Saludo del Paciente

**Date:** _____

| Nombre del Paciente : | M: ☐ F: ☐ | Fecha de Nacimiento: |
|---|---|---|

## ALERGIAS

MEDICAMENTOS: _____

ALIMENTOS: _____

OTROS: _____

## MEDICAMENTOS

PRESCRIPCIONES: _____

SIN PRESCRIPCIÓN:_____

_____

## HISTORIA PRENATAL

Enfermedades durante el embarazo : Y ☐ N ☐

Peso de nacimiento: _____

Tipo de nacimiento: _____

Complicaciones: _____

Embarazo Completo: Y ☐ N ☐

Prematuro: Y ☐ N ☐

## CRECIMIENTO Y DESARROLLO

Normal:

Si es anormal, por favor explique: _____

_____

_____

_____

_____

## HISTORIAL (MARQUE TODOS LOS QUE APLIQUE)

___ Infección de oídos recurrente
___ Perdida de audición
___ Varicela
___ Desorden de la sangre
___ Depresión
___ Convulsiones
___ Alergias
___ HIC/SIDA
___ Resfríos Frecuentes
___ Dolores Frecuentes de garganta
___ Amigdalitis
___ Evenenamiento de Plomo
___ Desordenes de alimentación
___ Problemas de aprendizajes
___ Problemas de Drogas/ Alcohol
___ Asma/Bronquitis
___ Infección Urinaria
___ Anemia Falciforme
___ Dolor de cabeza/ Migrañas
___ Retrasos de desarrollo
___ Orinarse en la Cama
___ Tuberculosis
___ Problemas Estomacales
___ Soplo Cardiaco
___ Desorden de Salud Mental

Al dia con inmunizaciones : Y ☐ N ☐

Lesiones: _____

Cirugias: _____

Hospitalizaciones _____

## HISTORIAL SOCIAL

Idioma Primario: _____ Grado escolar: _____

Anotaciones/Como wsta haciendo en la escuela: _____

## FAMILY HISTORY (MARQUE TODOS LOS QUE APLIQUE)

___ Asma
___ Desorden Sanguíneo / anemia
___ Hipertensión
___ Convulsiones
___ Enfermedades del Corazón
___ HIC/AIDS
___ Anemia Falciforme
___ Soplo Cardiaco
___ Desorden de Salud Mental
___ Enfermedad de los riñones
___ Defectos de nacimiento
___ Problemas de Drogas/ Alcohol
___ Cancer
___ Dolor de Cabeza / Migrañas
___ Diabetes
___Problemas de la Tiroides
___ Tuberculosis
___ Síndrome de muerte repentina de infantil

**COMPLETED BY:** _____ **ARNP/PHYSICIAN:** _____

# Notice of Privacy Practices

**NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES: This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

Your Kid's Urgent Care is required to maintain the privacy of your health information and to provide you with a notice of its legal duties and privacy practices. We will not use or disclose your health information except as described in this Notice. This Notice applies to all of the medical records generated by Your Kid's Urgent Care as well as records we receive from other providers.

**USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION IN TREATMENT, PAYMENT & HEALTH CARE OPERATIONS**

***Treatment:*** Your Kid's Urgent Care may use and disclose your protected health information in the course of providing or managing your health care as well as any related services. For the purpose of treatment, we may coordinate your health care with a third party. For example, we may disclose your protected health information to a pharmacy to fulfill a prescription for medication, to a radiology facility to order an X-ray, or to another physician who is assisting in your health care. In addition, we may disclose protected health information to other health care providers related to the treatment provided by those other providers.

***Payment:*** When needed, Your Kid's Urgent Care will use or disclose your protected health information to obtain payment for its services. Such uses or disclosures may include disclosures to your health insurer to get approval for a recommended procedure or to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. When obtaining payment for your health care, we may also disclose your protected health information to your insurance company to demonstrate the medical necessity of the care or for utilization review when required to do so by your insurance company. Finally, we may also disclose your protected health information to another provider where that provider is involved in your care and requires the information to obtain payment.

***Health Care Operations:*** Your Kid's Urgent Care may use or disclose your protected health information when needed for the practice's health care operations for the purposes of management or administration of the practice and for offering quality health care services. Health care operations may include: (1) quality evaluations and improvement activities; (2) accreditation, certification, licensing, or credentialing activities; (3) reviews and audits such as compliance reviews, medical reviews, legal services, and maintaining compliance programs; and (4) business management and general administrative activities. In addition, we may disclose your protected health information to another provider or health plan for their health care operations.

***Other Uses and Disclosures:*** As part of treatment, payment, and health care operations, Your Kid's Urgent Care, may also use or disclose your protected health information to: (1) inform you of potential treatment alternatives or options; or (2) inform you of health-related benefits or services that may be of interest to you.

**USES & DISCLOSURES TO WHICH YOU MAY OBJECT**

***Family/Friends:*** Your Kid's Urgent Care may disclose your protected health information to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose protected health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If you have any objection to the use and disclosure of your protected health information in this manner, please tell us.

**USES & DISCLOSURES THAT ARE REQUIRED OR PERMITTED WITHOUT YOUR AUTHORIZATION**

***Research:*** Under certain circumstances, Your Kid's Urgent Care, may use and disclose your protected health information to approved clinical research studies. While most clinical research studies require specific patient consent, there are some instances where a retrospective record review with no patient contact may be conducted by such researchers. For example, the research project may involve comparing the health and recovery of patients who received one medication for their medical condition to those who received a different medication for that same condition.

***Regulatory Agencies:*** Your Kid's Urgent Care may disclose your protected health information to government and certain private health oversight agencies, e.g., the Department of Public Health and Environment or the Board of Medical Examiners, for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary to monitor compliance with the requirements of government programs.

***Law Enforcement/Litigation:*** Your Kid's Urgent Care may disclose your protected health information for law enforcement purposes as required by law or in response to a court order or other process in litigation.

***Public Health:*** As required by law, Your Kid's Urgent Care may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury or disability. For example, we are required to report the existence of a communicable disease, such as acquired immune deficiency syndrome ("AIDS"), to the Department of Public Health and Environment to protect the health and well-being of the general public.

# Notice of Privacy Practices

***Workers' Compensation:*** Your Kid's Urgent Care may release protected health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

***Military:*** Your Kid's Urgent Care may disclose your protected health information as required by military command authorities, if you are a member of the armed forces.

***As Otherwise Required or Permitted By Law:*** Your Kid's Urgent Care will disclose your protected health information in any situation in which such disclosure is required by law (e.g., child abuse, domestic abuse) or any other use permitted under HIPAA, its amendments or regulations.

**USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION:**

Other than the circumstances described above, Your Kid's Urgent Care, will not disclose your protected health information unless you provide written authorization. An authorization is specifically required in most situations involving uses or disclosures of protected health information for marketing purpose, for the sale of protected health information, or for psychotherapy purposes. You may revoke your authorization in writing at any time except to the extent that we have already taken action in reliance upon the authorization.

**YOUR RIGHTS RELATED TO YOUR HEALTH INFORMATION:**

Although all records concerning your treatment obtained at Your Kid's Urgent Care are the property of Your Kid's Urgent Care, you have the following rights concerning your protected health information:

- ***Obtain a copy of this Notice of Privacy Practices upon request***
- ***Right to Confidential Communications:*** You have the right to receive confidential communications of your protected health information by alternative means or at alternative locations. For example, you may request that we contact you at work or by mail.
- ***Right to Inspect and Copy:*** You generally have the right to inspect and copy your protected health information, except as restricted by your physician or by law. Further, if we maintain your health records on an electronic health records system, you have the right to request an electronic copy of your health records.
- use or disclose your protected health information, except to the extent that action has already been taken in reliance on your authorization.
- ***Right to Notice of Breach of Security:*** You have the right to be notified in the event of a breach of unsecured protected health information occurs.
- ***Right to Opt Out:*** You may be contacted for certain fund-raising purposes and you have the right to opt out of receiving such communications.
- ***Right to Amend:*** You have the right to request an amendment or correction to your protected health information. If we agree that an amendment or correction is appropriate, we will ensure that the amendment or correction is attached to your medical record.
- ***Right to an Accounting:*** You have the right to obtain a statement of the disclosures that have been made of your protected health information other than by your authorization, other than to you and other than for the purpose of treatment, payment or routine operational purposes.
- ***Right to Request Restrictions:*** You have the right to request restrictions on certain uses and disclosures of your protected health information. If we agree, we will abide by the restrictions. Additionally, if you (or anyone on your behalf besides a health plan) pay for the care or services at issue in full out of your own pocket, we are required to comply with your request not to disclose your protected health information to a health plan, unless required by law to do so.
- ***Right to Receive a Copy of this Notice:*** You have the right to receive a paper copy of this Notice, upon request, if this Notice has been provided to you electronically.
- ***Right to Revoke Authorization:*** You have the right to revoke your authorization to use or disclose your protected health information, except to the extent that action has already been taken in reliance on your authorization.
- ***Right to Notice of Breach of Security:*** You have the right to be notified in the event of a breach of unsecured protected health information occurs.

**For More Information Regarding How to Exercise These Rights:** If you have questions or would like more information regarding any of the rights listed above, please contact our main line, # (727) 348-0886.

**If You Believe That Your rights Have Been Violated:** You may file a complaint by calling our main line at (727) 348-0886 or with the U.S. Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

# CONSENT FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

## Notice of Privacy Practice

I hereby give consent to **Your Kid's Urgent Care** and all health care providers furnishing care within the practice to use and disclose health information for the purposes of treatment, payment and health care operations.

I further authorize **Your Kid's Urgent Care** to furnish information from my medical records as requested by other physicians or medical care facilities, hospitals or home health agencies for my continued care and treatment or for peer review activities.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe information may identify me.

I understand that I have a right to request **Your Kid's Urgent Care** to restrict how they use and disclose my protected health information for the purposes of treatment, payment or health care operations.

**Your Kid's Urgent Care** is not required to grant my request, but if they do, the restriction will be binding on **Your Kid's Urgent Care.**

I acknowledge that I have received the Notice of Privacy Practices for **Your Kid's Urgent Care** which provides more detailed information about how **Your Kid's Urgent Care** may use or disclose my protected health information.

We reserve the right to change the terms of it's Notice of Privacy Practices at any time. If we do make changes to the terms of the Notice of Privacy Practices, you may obtain a copy of the revised notice by requesting a copy from our front desk staff.

_____ _____/_____/_____

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

_____

**Parent/Legal Guardian Printed Name**

_____ _____/_____/_____

**Parent/Legal Guardian Signature** **Date**

# CONSENTIMENTO DE USO DE INFORMACION PROTEGIDA DE SALUD

## AVISO DE LA PRIVACIDAD DE LA OFICINA

Doy mi consentimiento para **Your Kid's Urgent Care** y todos los proveedores de atención médica que brindan atención dentro de la práctica usen y divulguen la información de salud a los fines de tratamiento, pago y operaciones de atención médica.

También autorizo **Your Kid's Urgent Care** para proporcionar información de mis registros médicos a solicitud de otros médicos o centros médicos, hospitales o agencias de atención domiciliaria para mi cuidado y tratamiento continuo o para actividades de revisión entre doctor.

Mi "información de salud" protegida se refiere a la información de salud, incluida la información demográfica, recopilada de mí o creada o recibida por mi médico, otro proveedor de atención médica, un plan de salud o una cámara de compensación de atención médica. Esta información de salud protegida se relaciona con mi salud o condición física o mental pasada, presente o futura y me identifica, o existe una base razonable para creer que la información puede identificarme.

Entiendo que tengo derecho a solicitar cómo Your Kid's Urgent Care usan y divulgan mi información de salud protegida para fines de tratamiento, pago u operaciones de atención médica

**Your Kid's Urgent Care** no está obligado a otorgar mi solicitud, pero si lo hacen, la restricción será vinculante para **Your Kid's Urgent Care .**

Reconozco que he recibido el aviso de prácticas de privacidad de **Your Kid's Urgent Care** que proporciona información más detallada sobre cómo **Your Kid's Urgent Care** puede usar o divulgar mi información de salud protegida

Nos reservamos el derecho de cambiar los términos de su aviso de prácticas de privacidad en cualquier momento. Si realizamos cambios en el término del aviso de prácticas de privacidad, puede obtener una copia del aviso revisado solicitando una copia de nuestro personal de recepción.

_____ _____/_____/_____

**Nombre de Patiente** **Fecha de Nacimiento**

_____

**Padre/Guardian Legal Nombre Printado**

_____ _____/_____/_____

**Firma Padre/Guardian Legal** **Fecha**

Your Kid's URGENT CARE

**Office Location:** _____
**Room:** _____

***Welcome to Your Kid's Urgent Care! Our goal is to get your child back home and feeling better as quickly as possible. However, please remember we are an urgent care clinic and it is necessary for us to see patients according to severity. Your patience is greatly appreciated.***

Date: _____/_____/_____ Time: _____ Primary Phone: _____

Patient Name: _____ DOB: ___/___/____ Relationship to Patient: _____

Patient Address: _____
Street Address Apt# City, State, Zip

Pediatrician Name: _____

Insurance: _____

Email Address: _____

Why are we seeing your child today? _____
Does your child have a history of seizures? Yes No
Is your child allergic to any medications? Yes No Medication: _____
If yes what happens when they take this medication: _____
Is your child in respiratory distress? Yes No
Does your child have a fever? Yes No Temperature : _____°
Circle last medication given if any: Tylenol/Motrin/Other_____ given @ _____:_____ am/pm
Pharmacy Name _____ Address_____ Phone _____

**How did you hear about us?**

☐ Drive By/Saw Sign ☐ Event ☐ Social Media ☐ Friend/Family ☐ Internet Search
☐ Print Publication ☐ Primary Care ☐ Direct Mail ☐ Other _____

****BEYOND THIS POINT FOR OFFICE USE ONLY****

Ht. _____ Wt. _____ Temp_____Pulse _____ RR_____ O2%_____ B/P_____
AX/ORL/REC (circle one)

**Insurance Plan:** _____ ☐ Commercial ☐ Medicaid HMO ☐ Private Pay

**Payment Collected?:** ☐YES ☐NO $_____ Form of Payment: ☐ Check ☐ Cash ☐ Credit Card

☐ New Patient ☐ Established Patient

**Notes:**

Your Kid's URGENT CARE

**Office Location:** _____
**Room:** _____

***¡Bienvenido a Your Kid's Urgent Care! Nuestro deseo es que su hijo regrese a su hogar sintiendose mejor lo mas pronto possible. Por favor, tenga en cuenta que somos una clínica de atención urgente y es necesario que veamos a los pacientes según la gravedad. Su paciencia es sumamente apreciada.***

Fecha: _____/_____/_____ H: _____ Numero Primario: _____

Nombre de Paciente: _____ Fecha de Nacimiento: ___/___/____

Relacion con Paciente: _____

Direccion del Paciente: _____
Direccion Numero de Apartamento Ciudad, Estado, Codigo Postal

Nombre del Pediatra: _____

Seguro Medico: _____

Correo Electronico: _____

Cual es la razón de la visita de hoy? _____
Tiene su hijo/a historia de convulsiones? Si No
Tiene su hijo/a alergia a algún medicamento ? Si No Medicamento: _____
Cual es la reacción? _____
Esta su hijo/a con falto de aire ? Si No
Tiene su hijo/a fiebre? Si No Temperatura: _____°
Circule la ultima medicina dada a su hijo/a Tylenol/Motrin/Otro_____ dada @ _____:_____ am/pm

Nombre de Farmacia: _____

Direccion: _____ Telefono: _____

**Como supo de nuestras oficinas?**

☐ Manejand0/Tablon de Anancio ☐ Evento ☐ Medios Sociales ☐ Amistad/Familia ☐ Busqueda en el internet
☐ Publicacion ☐ Doctor Primario ☐ Correo ☐ Otro _____

****BEYOND THIS POINT FOR OFFICE USE ONLY****

Ht. _____ Wt. _____ Temp_____Pulse _____ RR_____ O2%_____ B/P_____
**AX/ORL/REC (circle one)**

**Insurance Plan:** _____ ☐ Commercial ☐ Medicaid HMO ☐ Private Pay

**Payment Collected?:** ☐ YES ☐ NO $_____ Form of Payment: ☐ Check ☐ Cash ☐ Credit Card

☐ New Patient ☐ Established Patient

**Notes:**