Patient Name:		**Date of Birth:**
Mailing Address:		**APT#:**
City:	**State:**	**Zip Code:**
Can we contact you through our patient portal? YES or NO	**Email:**	
Home Phone #:	**Cell Phone #:**	**Work Phone #:**
Sex: (CIRCLE ANSWER) Male Female Transgender	**Marital Status:** (CIRCLE ANSWER) Single Married Partnered Divorced Widowed	
Physician Name:		**Phone #:**
Physician Address:		
Pharmacy Name and Address:		
Emergency Contact:	**Phone #:**	**Relationship to Patient:**

PRIMARY INSURANCE INFORMATION

Insurance:	**ID #:**	
Policy Holder Name:	**DOB:**	**Relationship to Patient:**
Policy Holder Address:		
Policy Holder Social Security #:		

Oakhurst office email: Info@familyfirst-urgentcare.com

Toms River office email: InfoTR@familyfirst-urgentcare.com

FINANCIAL POLICY

Patient Name:_____Date of Birth: _____

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

Individual's Financial Responsibility

- I understand that I am financially responsible for any co-pay, co-insurance, deductible, or the cost of any non-covered service.
  **Please be aware that some services provided may not be covered and/or considered reasonable and necessary under the Medicare program and/or other medical insurances.*
- I understand that payment in **FULL** is due at the time services are rendered.
- I understand that if my insurance requires a referral, I must obtain it prior to my visit.
- I understand that I will be responsible for any charges should my insurance deem a service "not payable".
- Should payment be sent directly to me, I understand it is my responsibility to forward payment directly to MVP Medical Associates, d.b.a. Family First Urgent Care
- If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.

COMPLETION OF FORMS: $25.00 to complete physical/pre-employment/sports physicals/insurance request forms if not provided at time of service. *Please allow **48 hours** for completion.*
COLLECTIONS: Any fees or surcharges imposed by a collection agency will be your responsibility, along with the full outstanding balance from your visit.
MEDICAL RECORDS: Request for medical records must be made in writing. Please allow ***72 hours*** for completion.

I authorize the release of any information necessary to process the health claims for my care.

I authorize the insurance company to forward payment directly to the physicians.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE**

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have read and received a copy of the HIPAA Notice of Privacy Practices

_____ _____ ____/____/____

Printed Name Patient Signature Date

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLEASE CHECK ALL THAT APPLY

I authorize my physician/clinical staff to disclose my protected health information to:

- ☐ Myself only
- ☐ My spouse or significant other (specify names) _____
- ☐ My parent(s) (specify names) _____
- ☐ Others (please specify relationship) _____

I would like to be contacted in the following manner:

Home Telephone _____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Do not leave messages or medical information

Cellular Telephone _____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Do not leave messages or medical information

Written Communication

- ☐ OK to email through our patient portal
- ☐ OK to mail to my home address

I grant Family First Urgent Care permission to obtain information from external sources (Pharmacy) regarding medications that have been prescribed to me.

- ☐ [Check here if you **DO NOT** consent for external prescription history]

_____ ____/____/____

Patient Signature Date

Name:_____Date of Birth:_____

CURRENT MEDICATIONS (prescription and over the counter)	**DOSAGE**	**FREQUENCY**

PAST MEDICAL HISTORY (Please ***CIRCLE*** all that apply to you)			
Alcohol/Drug Abuse	COPD/Emphysema	Heart Murmur	Liver Disease
Allergies	Coronary Artery Disease	Hepatitis	Pacemaker
Anemia	Congestive Heart Failure	High Blood Pressure	Psychiatric Problems
Atrial Fibrillation	Depression	High Cholesterol	Seizure
Asthma	Diabetes	Hypo/hyperthyroidism	Stroke
Cancer	Heart Attack	Kidney Disease	Vascular Disease

- Please list any additional medical diagnoses that you have that are not mentioned above:

  _____

- Please list any significant Family Medical history:

  _____

ALLERGIES	**REACTION** (hives, anaphylaxis, etc.)

PAST SURGERIES	**DATE**	**SURGEON**

- Smoking History (Please circle): Nonsmoker/Former/Current
- Do you drink alcohol (Please circle)? Yes/No