EXECUTIVE URGENT CARE
AT INDIAN WELLS

Name: _____ D.O.B. _____
Last First

OFFICE USE ONLY

Date: _____ Pateint Record#: _____ Insurance: _____

T _____ P _____ B/P _____ R _____ 02% _____ WT _____ HT _____

TO BE COMPLETED BY PATIENT: Please complete the following information below

Primary Doctor: _____ PH: _____ Fax: _____

Local Pharmacy: _____ **Pharmacy Location:** _____

Chief complaint/ Reason for your visit: _____

_____

Approx. onset of symptoms: _____

Any pain/ discomfort associated with problem? _____
Pain/ discomfort level: 1 2 3 4 5 6 7 8 9 10

Was this the result of a work injury? O Yes O No

Medications: Strength/ Frequency: Please list **all** current medications

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Allergies – Please list any drug/food allergies _____

_____

Personal Medical History – Check the box if you have or have had any of the following:

O Arthritis	O Gastrointestinal	O Kidney	O Psychiatric
O Blood Disorder	O Genitourinary	O Liver Disease	O STD's
O Cancer: Type_____	O Heart Disease	O Lung Problems	O Skin Disorders
O Diabetes	O High Blood Pressure	O Musculoskeletal	O Thyroid
O ENT	O High Cholesterol	O Nero: Stroke, Seizure…	O Other_____

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Surgeries: Please list all surgeries (including cosmetic) you have had done and the year it was done

_____

_____

O SMOKE/SECONDHAND SMOKE
How many: _____ per day
How many years? _____

O ALCOHOL
How many: _____ daily/weekly/socially

O STREETDRUGS_____

Family History- (List illnesses that were diagnosed **before the age of 65**)
Father: _____
Mother: _____

Immunizations: Check the box if the immunizations is up to date and please write the date it was given

O Tetanus (**date of last**) _____ O Flu Shot _____ O Other_____

Females Only:

Approx. first day of last menstrual: _____

Menstrual History: Age at onset _____ Pregnancies: Number of pregnancies _____ Live births _____ Miscarriages_____

Date of last: (month and/or year)

Mammogram _____ Fecal Occult Blood Test _____ Bone Density_____ PAP Smear_____

Males Only:

Date of last: (month and/or year)
Prostate Exam _____ Fecal Occult Blood Test _____ Bone Density_____ PSA Screening _____

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PLEASE COMPLETE ALL INFORMATION

FIRST NAME	MIDDLE NAME	LAST NAME

DATE OF BIRTH	SSN	MAIN PHONE

MAILING ADDRESS	SEX M( ) F( )

CITY	STATE	ZIP	MARITAL STATUS M( ) S( ) D( ) W( )

PRIMARY DOCTOR & LOCATION	PHARMACY NAME & LOCATION	EMAIL

EMPLOYER NAME & ADDRESS

CITY	STATE	ZIP	PHONE

EMERGENCY CONTACT	MAIN PHONE	RELATION

HOW DID YOU HEAR ABOUT US? SIGNAGE( ) INSURANCE( ) DOCTOR( ) INTERNET( ) OTHER( )

PARENT/GUARDIAN OR INSURER'S INFORMATION

FULL NAME	RELATION	DATE OF BIRTH	SEX M( ) F( )

MAILING ADDRESS	MAIN PHONE

CITY	STATE	ZIP

A photo ID is **REQUIRED**. If you would like us to bill your insurance, a copy of your insurance card(s) is **REQUIRED** at the time of registration. If for any reason you do not have your insurance card(s) for us to scan, you will be considered a **CASH PAY PATIENT**.

AUTHORIZATION TO PAY BENIFITS TO PROVIDER: I hereby authorize payment directly to the Executive Urgent Care of Indian Wells for the Medical Benefits for services rendered. I hereby authorize Executive Urgent Care of Indian Wells to release any and all of my information necessary to process this claim.

Signature	Date

EXECUTIVE URGENT CARE AT INDIAN WELLS

FINANCIAL POLICY

Here at Executive Urgent Care of Indian Wells, we are committed to providing our patients with quality medical care and to avoid any misunderstandings, we have created this finacial policy to clearly outline the patient and practice finacial responsibilities.

PATIENT RESPONSIBILITY

- It is the patient's responsibility to know what is covered under the insurance plan and what is not covered under the insurance plan. In addition, it is the patient's responsibility to verify which facility is contracted with the insurance plan. To find more information about the insurance plan you may call the number on the insurance card.
- It is the patient's responsibility at the time of service to pay any and all co-payment, deductible, co-insurance, or any other charges specified by the insurance plan. Medical services that are not covered by the insurance plan are the responsibility of the patient.

PAYMENT POLICY

- **Payments will be collected at the time of service**. We accept cash, debit cards and all major credit cards.
- The adult accompanying a minor is responsible for any payments due at the time of service.

INSURANCE BILLING

- In order to bill your insurance company we will require all necessary information at the time of service.
- Once we receive payment from the insurance company, if for any reason there is a remaining balance, that is the patient's responsibility, a statement will be mailed to the attention of the patient to the address we have on file. Balance will be due upon receipt. Please plan accordingly to settle the balance or contact the billing department at (877) 374-9148.

OUT OF NETWORK & NON INSURED

- Payment must be paid in full at the time of service.
- Labs, X-Ray, or any other procedures will be at an additional charge.
- A code summary will be provided to the patient to submit to any out of network insurance companies for reimbursement. If for any reason the insurance company does not pay for the full cost of the services rendered, the patient will be considered responsible.

Our practice firmly believes that a good patient-provider relationship is based upon understanding and good communication. If you have any questions or concerns please feel free to talk to our staff. We are here to help you. Your signature below confirms that you have read and understand this financial policy.

Patient Signature _____ Date _____

EXECUTIVE URGENT CARE AT INDIAN WELLS

CONFIDENTIAL COMMUNICATION AUTHORIZATION

As required by Health Information Act of 1996 (**HIPPA**) you have the right to request that communications concerning your personal health information be kept confidential unless you give written authorization.

I may revoke this authorization at any time, provided that the revocation is in writing to the practice.

I hereby request the use of the following methods of communication related to my personal health, treatment or payment for treatment of:

Please indicate which method(s) you would like for us to communicate with you.

- Cell Phone_____
- Home Phone_____
- Work Phone_____

EUCIW will only speak to the patient regarding any health and/or personal information unless the bottom portion is filled out and signed by patient/patient representative.

I am giving Executive Urgent Care of Indian Wells my permission to speak to the following person(s) regarding any health and/or personal information:

NAME	RELATION	MAIN PHONE
NAME	RELATION	MAIN PHONE
NAME	RELATION	MAIN PHONE

PATIENT SIGNATURE PRINT NAME

Date_____ Witness_____

EXECUTIVE URGENT CARE AT INDIAN WELLS

HEALTH INFORMATION & NOTICE OF PRIVACY

I authorize the use and/or disclosure of my protected health information as set forth below.

1. The only protected health information that may be used or disclosed is any information provided by me to my provider, or any information gathered or ascertained by my provider as a result of any physical condition, medical history, radiological or other medical procedures.

2. The name, or other specific identification, of the person(s) or class of person(s) authorized to make the use/disclosure of my protected health information: My provider, his medical or technical assistants, and all duly authorized office personnel or staff of the provider.

3. The name, or other specific identification, of the person(s) or class of person(s) authorized to make the use/disclosure of my protected health information: Executive Urgent Care of Indian Wells and its representatives, agents and subcontractors (included but not limited to adjustors, nurses, and case managers) of the entity that providers arranges for applicable workers compensation or other benefits (hereafter, the workers compensation carrier) all duty authorized representative of my employer (or such other party for whom I have rendered services as necessary and appropriate for the review and disposition of any workers compensation or other similar benefits (hereafter the employer)

4. My protected health information will be used and disclosed for the following purposes only (each purpose listed and described): To insurance carriers for its use in the provision of certain provider quality assessment services, appropriate payment for professional services rendered to EUCIW, to the workers compensation carrier for purposed of reviewing and assessing a treatment plan and otherwise overseeing the claim and employees, as necessary for the review and disposition of any workers compensation claims or similar benefits.

5. This authorization will expire at such time (1) my treatment with the provider concludes, (2) all payment for such treatment has been appropriately made and accounted for, (3) all quality assessment or other operational use of my health information has been made, (4) all information has been disclosed as appropriate to the workers compensation carrier (or other benefits carrier) and/or my employer.

6.I may revoke this authorization in writing at any time by contacting my provider or his/her staff at the following address and telephone number, except to the extent that my provider has taken action in reliance on his authorization:

74-785 Highway 111, Suite 100
Indian Wells, CA 92210
Phone (760) 346-3932 Fax (760) 346-8584

7. I understand that I may refuse to sign this authorization. If I refuse to sign I understand that my provider will not condition my treatment, payment, and/or enrollment in a health plan or eligibility for benefits (if applicable) or whether I provide authorization for the requested use/disclosure except: (1) if my treatment is related to research, or (2) if health care services are provided to me solely for the purpose of creating protected health information for disclose to a third party.
8. I understand that here is a potential for information used/disclosed pursuant to this authorization to be disclosed by the recipient of the information and to no longer be protected by federal or state law.

I hereby certify that I have read and understand the prevision set forth in this authorization and agree to its terms.

Patient Signature _____ Date _____

EXECUTIVE URGENT CARE AT INDIAN WELLS

NARCOTIC POLICY

To our valued patients,

Due to the changing landscape of medical care and concerns over improper prescribing and overuse of narcotic pain medications, Executive Urgent Care will no longer issue prescriptions for chronic pain medications or other controlled substances that are being written by primary care or specialty providers.

These medications must be managed by your specialist or primary care provider. If your primary care or specialty provider is unable to see you and is willing to approve EUCIW writing you a short-term prescription until that provider can schedule a face-to-face visit with you, have the provider call EUCIW and speak to our office staff or provider on duty.

EUCIW will do all we can to assist in writing a short-term prescription. This will be on very limited basis, and will not be construed as routine practice.

We urge patients to schedule appropriate and timely appointments with their primary care or specialty providers to facilitate ongoing management of chronic medication needs.

We appreciate your understanding and look forward to caring for any of your other urgent care needs.

The Physicians, Providers and Staff of Executive Urgent Care

Patient signature_____ Date_____

EXECUTIVE URGENT CARE AT INDIAN WELLS

A MESSAGE TO OUR PATIENTS ABOUT ARBITRATION

Our goal is to provide quality medical care to our patients in a way that will avoid disputes. We know that most problems occur as a result of miscommunication. So, if you have concerns about your medical care, please discuss them with us.

Please read the attached contract entitled "Physician-Patient Arbitration Agreement". By signing the contract, we are agreeing that any dispute arising out of the medical services you receive will be resolved in binding arbitration before an arbitration panel instead of by a lawsuit in a court of law.

Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

We believe that the method of resolving disputes in arbitration spares the parties some of the rigors of a court trial and the publicity which may accompany judicial proceedings.

Thank you for your understanding,

EUCIW Staff

EXECUTIVE URGENT CARE AT INDIAN WELLS

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompletely rendered by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.
All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician or patient to collect or contest any medical fee shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any malpractice claim, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select and arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.
Either party shall have the absolute right to arbitrate separately the issue of liability and damages upon written request to the neutral arbitrator.
The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a poor additional party ina court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.
The parties agree that the provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedures Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgement or summary adjunction in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.5; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4:**General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date of notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provider for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to the arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date that it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of the first medical services _____
Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Physician's or Authorized Representative's Signature Date

By: _____ _____
Patient's or Patient Representative's Signature Date

EXECUTIVE URGENT CARE OF INDIAN WELLS
74785 HWY 111 STE 100
INDIAN WELLS CA 92210
Print or Stamp Name of Physician, Medical Group, or Association Name

By: _____
Print Patient's Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the patient. Original is to be filed in Patient's medical records.