Welcome to Surfside Urgent Care of Laguna Beach!

FREE WIFI (*Surfsideguest,* Password: *getwellnow)*

Please fill out ALL forms completely ***PLEASE PRINT CLEARLY***

Patient Name				Date of Birth	
Mobile Phone				Home Phone	
Address				City	
State		Zip		Social Security	
Primary Care Physician Name		Primary Care Phone Number			

Do we have permission to leave a message on your answering machine? □ Yes □No

Pharmacy Name & Phone Number:_____

Email		Work Phone	

Emergency Contacts

Name		Phone		Relationship	
Name		Phone		Relationship	

How did you learn about our practice?

□ Google □ Facebook □ Yelp □ Insurance □ Maps □ Drive by □ Referred by: _____

Is this for a work-related injury?	YES	NO
Is this visit for a motor vehicle accident?	YES	NO
Here for COVID Testing?	YES	NO
Have you been exposed to anyone COVID positive?	YES	NO
Will COVID testing be used for travel?	YES	NO
Will COVID testing be used for surgery?	YES	NO

Primary reason for today's visit	Example: Problem Location Duration

32341 Coast Highway, Laguna Beach CA 92651, Tel 949.715.7278, Fax: 949.715.9799

FRONT & BACK

Medical Questionnaire

Name: _____ Date of Birth: _____

Medical History: Today's Date: _____

- ☐ **Heart Disease or Cardiovascular disease**
  - ☐ Atrial fibrillation
  - ☐ Coronary Artery Disease
  - ☐ High Blood Pressure
  - ☐ High Cholesterol
  - ☐ Murmur
- ☐ **Respiratory or Lung disease**
  - ☐ Asthma
  - ☐ COPD
- ☐ **Liver disease**
- ☐ **Cancer type** _____
- ☐ **Musculo-skeletal disease**
  - ☐ Arthritis
  - ☐ Back Pain
  - ☐ Joint Disease
  - ☐ Tendonitis
- ☐ Prostate Disease: _____
- ☐ Kidney Disease: _____

- ☐ **Neurological or psychiatric**
  - ☐ Anxiety
  - ☐ Depression
  - ☐ Headaches
  - ☐ Migraine
  - ☐ Seizures
- ☐ **Endocrine**
  - ☐ Low Thyroid (hypothyroid)
  - ☐ High Thyroid (hyperthyroid)
  - ☐ Diabetes Type I Type II
- ☐ **Infections**
  - ☐ HIV
  - ☐ Others:
- ☐ Other medical history: _____

Surgical History: _____

Family History: _____

Medications you are currently taking: _____

_____

Allergies to medications: _____

Cigarette Smoking: __None __#Packs per day/weeks Alcohol Use: __none __occasionally __1-4 drinks/week __ 5-10/wk

Recreational Drug Use: __No or What Type: __11-15 drinks/week __more then 16 per week

Review of Systems: *(circle please)*

General:	otherwise well	Fatigued Fever/Chills Lightheaded Weakness Weight changes
Skin:	no changes	Rash Lumps Sores Itching hair/nail changes
Head/Neck:	doing well	Sore Throat Vision changes Hearing changes Nasal issues Swollen glands
Respiratory:	breathing well	Wheezing Cough Rapid breathing Pain with deep breath Short of Breath
Heart:	no chest pain	Palpitations Racing heart Chest Pain
Abdomen:	doing well	Nausea Vomiting Diarrhea Constipation Abdominal Pain Black Stools
Bladder:	normal urination	Burning w/urination Urgency Frequency changes Urine color changes
Muscular:	doing well	Muscular aches weakness focal or diffuse
Joints:	doing well	Joint pains History of joint swelling Morning Stiffness
Neuro:	no headaches	Headaches Confusion Forgetful Neck Stiffness Slurred Speech
Psychiatric:	self-content	Sadness Nervous Poor concentration Obsessive thoughts Hearing voices

Other: _____

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NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the "Notice of Privacy Practices" of Surfside Urgent Care of Laguna Beach. Our "Notice of Privacy Practices" provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our "Notice of Privacy Practices" is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting Surfside Urgent Care at (949) 715-7278.

I acknowledge receipt of the "Notice of Privacy Practices" of Surfside Urgent Care.

If signed by someone other than patient, indicate relationship:_____

Signature: _____ Date: _____
(patient /legal representative)

Print Patients Name: _____ Print name: _____
(Patient) *(Legal representative)*

FOR OFFICE USE ONLY

Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment, describe the good faith effort made to obtain the individual's acknowledgment, and the reasons why the acknowledgment was not obtained.

Reasons why the acknowledgment was not obtained:

___Patient refused to sign this acknowledgment even though the patient was asked to do so and the patient was given the Notice of Privacy Practices.

___Other: _____

Signature: _____ Date: _____
(provider representative)

Print Name: _____
(provider representative)

FRONT & BACK

Surfside
URGENT CARE
OF LAGUNA BEACH

IMPORTANT: PLEASE READ OUR POLICIES BELOW BEFORE SIGNING.

FINANCIAL RESPONSIBILITY

ALL CO-PAYMENTS, CO-INSURANCES, AND DEDUCTIBLES ARE DUE AT THE TIME SERVICES ARE RENDERED. IF YOU ARE NOT INSURED, ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE.

_____ INITIAL

ACCEPTABLE FORMS OF PAYMENT INCLUDE DEBIT CARD, CREDIT CARD, AND CASH. WE DO NOT ACCEPT CHECKS .

_____ INITIAL

IF WE ARE BILLING YOUR INSURANCE FOR SERVICES RENDERED, YOU WILL BE RESPONSIBLE TO PAY FOR YOUR ESTIMATED PATIENT RESPONSIBILITY BASED ON OUR VERIFICATION OF YOUR BENEFITS THAT WE WERE ABLE TO OBTAIN PRIOR TO YOUR VISIT. PLEASE NOTE THAT VERIFICATION OF YOUR INSURANCE BENEFITS IS NOT A GUARANTEE OF PAYMENT BY YOUR INSURANCE COMPANY.

IF WE ARE UNABLE TO VERIFY YOUR INSURANCE ELIGIBILITY AND BENEFITS PRIOR TO YOUR VISIT, YOU WILL BE RESPONSIBLE TO PAY FOR ALL SERVICES RENDERED BASED ON YOUR INSURANCE'S ESTIMATED DISCOUNTED RATES. YOUR INSURANCE WILL BE BILLED FOR THE SERVICES RENDERED.

ONCE OUR OFFICE RECEIVES THE EXPLANATION OF BENEFITS FROM YOUR INSURANCE, YOU MAY BE BILLED FOR ANY ADDITIONAL PATIENT RESPONSIBILITY OR REFUNDED/CREDITED FOR ANY OVERPAYMENT COLLECTED BY OUR OFFICE. **PLEASE ALLOW** 4 **TO 6 WEEKS FOR YOUR INSURANCE TO PROCESS EACH CLAIM**. PLEASE CONTACT OUR OFFICE IF YOU HAVE ANY QUESTIONS OR CONCERNS ABOUT OUR BILLING PROCEDURE.

_____ INITIAL

IN-HOUSE PHARMACY

FOR YOUR CONVENIENCE, OUR OFFICE CAN DISPENSE SOME PRESCRIPTION MEDICATIONS NECESSARY TO TREAT YOUR MEDICAL CONDITION. PLEASE NOTE THAT OUR OFFICE DOES NOT BILL YOUR MEDICAL INSURANCE FOR MEDICATIONS DISPENSED IN OFFICE AND THAT YOUR PHARMACY INSURANCE BENEFITS DO NOT APPLY TO MEDICATIONS DISPENSED IN OFFICE. **ANY MEDICATIONS DISPENSED IN OFFICE ARE THE PATIENT'S RESPONSIBILITY AND ARE AN ADDITIONAL CHARGE TO YOUR RESPONSIBILITY FOR THE OFFICE VISIT.** FOR INQUIRIES REGARDING OUR MEDICATION PRICES, PLEASE FEEL FREE TO ASK ANY OF OUR STAFF MEMBERS. IF YOU PREFER TO USE AN OUTSIDE PHARMACY OF YOUR CHOICE, A PRESCRIPTION MAY BE PROVIDED TO YOU AT NO ADDITIONAL CHARGE.

_____ INITIAL

I, _____ have read and understand the above stated office policies.

Print Patient Name

Signature: _____ **Date:** _____

MEDICAL SERVICES AGREEMENT

Patient's Name: _____

1. **MEDICAL CONSENT**: I consent to any medical treatments or procedures which may be performed on an outpatient basis (including emergency treatment or services), which may include but are not limited to medications, injections, taking of medical photographs, laboratory procedures, and/or x-ray examinations provided to me under the general and special instructions of the physicians, staff, or other health care providers of Surfside Urgent Care of Laguna Beach, A Medical Corporation (herein referred to as "SUCLB") assisting my care.

2. **FINANCIAL AGREEMENT: I understand that all charges are due at the time of service.** I agree to pay SUCLB for all charges for healthcare services and professional services provided to me by physicians and other healthcare professionals. Acceptable forms of payment include Cash, Visa, MasterCard, Discover, Amex and Debit card. If I am a non-insured patient, I agree to pay for my visit in full at the time of service. **If SUCLB is a participating provider with my insurance company I understand that my co-pay, coinsurance, deductible and/or any outstanding balances are due at the time of service**. I understand that my insurance policy is a contract between myself and my insurance company; SUCLB is not involved. In order for SUCLB to file claims and accept payments from my insurance company, I understand that I must present current insurance information at each visit and that SUCLB will need to verify my health insurance coverage. In the event that SUCLB is not able to verify my insurance eligibility and benefits before my visit, I agree to pay for my visit in full at the time of service. A refund will be issued if my insurance pays for the visit. I also understand that I am financially responsible for any services not covered by my insurance company. When my spouse or a financial guarantor signs this agreement, the spouse or the financial guarantor shall be jointly and individual liable with me. Should my account(s) be referred to an attorney or a collection agency for the collection, the undersigned shall pay the actual attorney's fees (including costs) and collections expenses incurred in addition to the other amounts due. Unpaid accounts referred to outside agencies for collection shall bear interest at the current rate per year from the date of referral.

3. **INSURANCE AUTHORIZATION AND RELEASE:** I request that payment of authorized benefits, including Medicare, and any other government sponsored program, private insurance, and any other health plans be made to SUCLB for any services furnished by that provider. To the extent necessary to coordinate my health care or determine liability for payment and to obtain reimbursement for services rendered, I authorize SUCLB to disclose portions of or all of my records, including my medical records to any person or corporation which is or may be liable for all or any portion of SUCLB's charges, including but not limited to insurance companies, health care service plans, governmental agencies, or worker's compensation carriers. I authorize SUCLB to act as my agent to help me obtain any required pre-certification as well as acting as my agent to help me obtain payment from my insurance companies. I authorize my insurance companies to give SUCLB any information required to fulfill this function. This will remain in effect until revoked in writing.

4. **RELEASE OF MEDICAL INFORMATION:** I hereby authorize SUCLB to release any information in my chart to any practitioner, doctor, hospital, or medical institution to which I may be referred to assist in my care. Additionally, I authorize SUCLB to provide a copy of my medical records to my primary care physician (PCP) to allow for continuity of care.

5. **NOTICE OF PRIVACY PRACTICES:** By signing this form, you acknowledge receipt of the "Notice of Privacy Practices" of SUCLB. Our "Notice of Privacy Practices" provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Our "Notice of Privacy Practices" is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting SUCLB at 949-715-7278.

6. **IN-HOUSE PHARMACY:** I understand that, for my convenience, SUCLB can dispense some prescription medications necessary to treat my medical condition(s). I understand that my insurance will not be billed for medications dispensed and that my pharmacy benefits DO NOT apply to this service. **Any medication(s) dispensed in the office are my responsibility and are an additional charge to my office visit charge.** I also understand that if I prefer to use an outside pharmacy, a prescription can be provided to me at no additional charge.

7. **PERSONAL VALUABLES:** SUCLB shall not be liable for the loss of or damage to any money, documents, jewelry, glasses, dentures, furs, or other articles of unusual value and shall not be liable for loss or damage to any personal property.

SUCLB and the patient or the patient's representative, hereby enters into this agreement. The undersigned certifies that he/she has read and agree to the foregoing, received a copy thereof, and is the patient, the patient's representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

_____ _____ or _____ _____

Signature of Patient DATE Signature of Patient's Representative DATE

_____ _____ _____

Medical Practice's Representative DATE Name & Relationship of Representative to Patient