Date: _____

Greater Mobile Urgent Care
Quality care when minutes count

Patient Label

Reason for Visit Please write any symptoms you are having on the following lines:

_____

_____

Weight: _____ **Height: _____** **Age: _____** **Male** or **Female**

Is there a chance you could be pregnant?: Yes or **No**
(Any female between the ages of 8-80 seen for lower back pain nausea, or abdominal pain who has not had a hysterectomy will have a pregnancy test)

Primary Care Doctor: _____

Medicine Allergies: _____

In case we need to call in a prescription, please provide a location or phone # for your pharmacy:

_____

Check if you have any of the following health conditions:

	✔
Smoking	
Heart Problems	
Diabetes	
Cancer	
Type of Cancer	
Stroke	
High Blood Pressure	
Autoimmune Disease	

	✔
Asthma	
COPD	
Seizures	
Kidney Problems	
Hepatitis	
Thyroid Disease	
Other	

If you checked "yes" or "other" above please explain: _____

_____

Do you have a family history of: (circle) Hypertension COPD CAD Diabetes Other: _____

Past Surgical History: _____

Current Medications	

Patient Information

Name: _____ SS#: _____ Date of Birth: _____

Mailing Address: _____
City State Zip

Home #: _____ Cell #: _____ Male or Female

Email Address: _____ May we add you to our email list? Y or N

Employer: _____ Work #: _____

Emergency Contact Name: _____ Phone #: _____

How did you hear about us? _____

Financial Responsible Party

Name: _____ Relationship to Patient: _____ Phone Number: _____

Date of Birth: _____ SS#: _____ _ Mailing Address:_____

City:_____ State: _____ Zip Code: _____

Insurance Information

Primary Insurance

Name of Insurance Company: _____

Name of Primary Insurance Card Holder: _____Relationship to Patient: _____

Primary Insurance Card Holder's **Date of Birth**: _____SS#: _____

If cards are not present please fill out the following information:

Contract/Member/Identification Number_____ Group Number_____

Claims Address (located on the back of the card) _____

Secondary Insurance

Name of Insurance Company: _____

Name of Secondary Insurance Card Holder: _____ Relationship to Patient: _____

Primary Insurance Card Holder's **Date of Birth**: _____ SS# :_____

If cards are not present please fill out the following information:

Contract/Member/Identification Number_____ Group Number_____

Claims Address (located on the back of the card) _____

PLEASE READ CAREFULLY BEFORE SIGNING

Financial Obligation/Assignment of Benefits

It is your responsibility to inform the front desk of any and all updates to your insurance plan as well as your personal information. Failure to do so could result in charges becoming patient responsibility. I assign and authorize payments to Greater Mobile Urgent Care, also known as GMUC.
It is your responsibility to understand your insurance plan. Please make sure to contact your provider to determine if Greater Mobile Urgent Care is in network and covered under your plan. If we are not network providers and your insurance company has an out of network deductible it will become patient responsibility. **Please be aware that you may be seen by a midlevel provider. You are responsible for verifying that midlevel providers (Physician's Assistant and Nurse Practitioners) are covered under your policy.**

You are responsible for the payment of charges for the health care that we provide. Unless your health insurance company, HMO or Medicare agreement with Greater Mobile Urgent Care, LLC prohibits it, payment is due at time of visit. Our office accepts cash, credit card and check payments. Patients that do not have benefits through a third party may speak with a front desk attendant regarding our fees.
By signing this document, I acknowledge that I am responsible for the financial obligation arising from the provision of care to myself, or the person for whom I am acting as a personal representative (such as an unemancipated minor). I acknowledge that I will incur the reasonable costs of collections including attorney's fee should I fail to satisfy my financial obligation. I am assigning and authorizing payments to Greater Mobile Urgent Care. *There will be a rebilling fee of 30% of the total charges added to all accounts not paid in full within 90 days of service.*

HIPAA Privacy Notice / Communication

Greater Mobile Urgent Care requires a signed consent before sharing medical information with a third party. For exclusions to this policy, please ask a front desk staff member for a copy of our Notice of Privacy Practices. Details regarding the protection of patient privacy are detailed on that document.

There are times when Greater Mobile Urgent Care will need to contact you in order to provide you with lab work or X-ray results. We will also make a follow-up call a few days after your visit to see if we can be of any further assistance. If the phone number listed is not the number you would like us to use to contact you please list an alternate number here _____.
If you would like to opt out of receiving a follow up call from us please check here_____. Otherwise, we will use the number provided to contact you. By signing below you agree that in order to service your account or collect monies owed, GMUC and/or our agents may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. You may also be contacted through text messages or emails, if you provide them. Other methods of contact include using prerecorded/artificial voice messages and/or use of automatic dialing device, as applicable.

Injection / Testing/ Consent to Treatment

Your physician will determine what treatment is most appropriate to address your symptoms and condition. I am authorizing GMUC to provide medical services to me. We want you to be informed of all possible medications he/she may recommend and their potential side-effects. Please read and sign below to give your consent for treatment and/or injections. **It is always your right as a patient to refuse treatment.**

Medication	Potential Side-Effects
Kenalog, Decadron, Norflex	Discoloration of the skin, fat necrosis (dimpling of the skin at the injection site), headache,
Solumedrol, Toradol,	drowsiness, mood swings, flushing, increased appetite, allergic reaction.
Bicillin, Rocephin	Nausea, vomiting, diarrhea, allergic reaction.
Dilaudid*, Morphine*, Ativan	Dizziness, drowsiness, weakness, nausea/vomiting, blurred vision, allergic reaction.
Tetanus and Diptheria, B-12	Redness or arm soreness, mild flu-like symptoms, allergic reaction.
Compazine, Phenergan, Benadryl, Zofran	Dizziness, drowsiness, dry mouth, nausea, muscle jerking/agitation, allergic reaction.

I understand the potential risks of the above medications and consent to recommended medical treatment.
Your physician will determine what tests are necessary to diagnose and treat you. It is always your right to refuse any recommended tests. If you are a female between the ages of 8 and 80 you may receive a pregnancy test. This is to ensure that appropriate treatment and medications are given. I understand by signing this for, I am authorizing GMUC to treat me for as long as I seek treatment or until I withdraw my consent in writing. *If you receive one of these medications and must leave your vehicle at GMUC you will have 24 hours to remove it before it will be towed at owner's expense. Thank you!

Greater Mobile Urgent Care respects the rights of patients and their families and encourages them to promptly bring concerns or complaints to our attention. A patient's care will never be compromised by the decision to lodge a complaint. Complaints can be directed to our office manager, Angela Collins at 251-445-7615 or emailed to us at info@gmucare.com.

✕ Patient Signature: _____ Date: _____

Please let the front desk know if you would like copies of your signed documentation. Thank you!