Immediate Care East
Walk-In Medical Treatment, PLLC

1600 Moseley Road, Suite 300 Victor, New York 14564
Phone:585.398.1275 Fax:585.398.1273
www.immediatecareeast.com

New Patient Intake Form

DATE:___________

Patient Information:

Patient Name: ____
Last First Middle

Patient Address: ____
Street City State Zip

Home Telephone Number: __________________________ **Mobile Telephone Number:** __________________________

Work Telephone Number: ____

Email Address: ____
(We do not sell, rent, lease or give away user email addresses. We will not share your email information with any third party who is not a business associate of Immediate Care East.)

Patient Demographics:

Patient Birthday: __________________
(*mm/dd/yyyy*)

Patient Sex: M or F
(*circle one*)

Patient Race: (*circle one*)
- White
- Black/African American
- American Indian/Alaska Native
- Asian
- Native Hawaiian/Other Pacific Island
- Other: __________________________
- I Decline to Specify/Unknown

Patient Ethnicity: (*circle one*)
- Hispanic/Latino
- Not Hispanic Latino
- I Decline to Specify/Unknown

Patient Language:
Primary Language: ____________________
Secondary Language: __________________

Insurance Information:

Name of Insurance Company: ____

Subscriber's Name: ____ **Subscriber's Date of Birth:** ____________________

Patient's Relationship to Subscriber: ____

Primary Care Physician Information:

____
Name of Current Primary Care Physician

Preferred Pharmacy Information:

____
Name Location of Pharmacy

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Patient Medical History Questionnaire

TODAY'S DATE:______________

____

PATIENT NAME

REASON FOR VISIT:

ONSET OF SYMPTOMS:

PAST MEDICAL HISTORY: *(circle Y or N, or check NONE)*

☐ NONE

Y	N	Anxiety ______________________________
Y	N	Asthma
Y	N	Back Pain
Y	N	Cancer ____________________ *(what kind?)*
Y	N	Depression __________________________
Y	N	Diabetes

If YES -- Insulin or Non-Insulin Dependent? (please circle)

Y	N	Emphysema
Y	N	Hypertension (high blood pressure)
Y	N	High Cholesterol
Y	N	Chronic pain __________________*(where?)*
Y	N	Reflux
Y	N	Stroke
Y	N	Ulcers
Y	N	Other:________________________________

SURGERIES:

- ☐ NONE
- ☐ Appendix
- ☐ Carpal tunnel
- ☐ Endoscopy
- ☐ Gall Bladder
- ☐ Heart
- ☐ Hernia
- ☐ Hysterectomy
- ☐ Knee Surgery
- ☐ Tonsils
- ☐ Tubal Ligation
- ☐ Tubes in ears
- ☐ Vasectomy
- ☐ Other:_________

ALLERGIES:

- ☐ NONE
- ☐ Aspirin
- ☐ Ibuprofen (Motrin)
- ☐ Sulfa (Bactrim)
- ☐ Codeine
- ☐ Penicillin
- ☐ Latex
- ☐ Other: ___________

SOCIAL HISTORY: (circle Y or N)

Y	N	Does Patient smoke cigarettes?
Y	N	Does anyone in Patient's home smoke?

FAMILY HISTORY: (circle Y or N)

Y	N	Is there a family history of asthma?
Y	N	Is there a family history of diabetes?
Y	N	Is there a family history of hypertension?

CURRENT MEDICATIONS*:

If you are currently taking more than one medication and have your list of medications with you, you may present your list to our receptionist who will scan it into our computer system.

MEDICATION:	NAME:
☐ NONE	____________________
☐ Blood Pressure	____________________
☐ Asthma	____________________
☐ Pain	____________________
☐ Sugar Medications	____________________
☐ Blood Thinner	____________________
☐ Stomach	____________________
☐ Birth Control	____________________
☐ Anxiety	____________________
☐ Depression	____________________
☐ Other:	____________________

**Please include supplements and vitamins*

I certify that the information contained on this page is true and accurately reflects the medical history for me or my child/ward.

X____

Signature of Patient or Parent

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Consent for Treatment and Release of Information

CONSENT FOR TREATMENT

Acting on my own behalf or on behalf of my child/ ward, and suffering from a condition requiring medical care, I hereby consent to the rendering of such care, which may include routine diagnostic procedures and such medical treatment as the medical staff of Immediate Care East: Walk-In Medical Treatment, PLLC ("ICE") consider to be necessary. I understand that, absent emergency or extraordinary circumstances, if further consent for tests or treatments is necessary and warranted by the condition of me or my child/ward, the procedure(s) will be explained to me by the physician or his/her representative as appropriate, and further consent sought from me at that time.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

As a convenience to our patients and in accordance with our Notice of Privacy Practices, it is the policy of ICE to release copies of your medical records to your primary care physician ("PCP") after each encounter at ICE. We will release your medical records for today's visit based upon the information you provide on your patient intake forms at the time of your visit. Today's Authorization supersedes all prior Authorizations on record with ICE.

YOU MUST CHECK ONE OF THE BOXES BELOW:

☐ I AUTHORIZE ICE TO RELEASE MY MEDICAL RECORDS FOR TODAY'S VISIT TO MY CURRENT PCP.

☐ I DO **NOT** AUTHORIZE ICE TO RELEASE MY MEDICAL RECORDS FOR TODAY'S VISIT TO MY PCP.

X ____

Signature of Patient (***or parent/legal guardian if patient is a minor***) **Date**

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Financial Agreement

Thank you for choosing us as your urgent care provider! We are committed to providing you with quality and affordable health care when you need it. We ask all patients to review and sign this policy, asking questions as necessary. A copy will be provided to each patient upon request.

Insurance: We accept assignment and participate with several insurance plans. If your insurance is not a plan we participate with, payment in full is expected at the time of your visit. Knowing your insurance benefits is your responsibility. Please contact your insurer with any questions you may have regarding your coverage.

Patient payment: All copayments and deductibles are to be paid at the time of service. This arrangement is part of your contract with your insurance company. If you have questions, please contact your insurance company directly.

Registration: All patients must complete our patient intake forms, which will be entered into our computer to maintain accurate information for proper billing. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of a claim. Most insurance companies have time filing restrictions; if a claim is not received within 30 days of the date of service, it can be rendered ineligible for payment and you will be responsible for the balance that remains.

Claims: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may require you to provide information about your visit here. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays or not. Your insurance benefit is a contract between you and the insurance company; we are not party to that contract.

Uninsured patients: We offer a "Self-Pay" option to our patients to pay "out of pocket" if they do not have insurance. Self-Pay patients receive a discount of approximately 20% off typical visit charges. The Self-Pay rate is considered a "GLOBAL FEE" which covers EVERYTHING for a patient's visit EXCEPT for the following items:

- if **lab work** is done here and specimens are sent out to ACM Laboratory
- if **x-rays** are done here and the images are sent to a radiologist for an over-read

***** All other charges are covered by the global fee for Self-Pay patients*****

Credit and collection: If your account is more than 120 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, it may be sent to a collection agency. If your account is sent to collection, it is the policy of this office to place a "hold" on your account, which means that you will not be able to receive medical services from our facility until you make payment in full of any past balances owed. The hold may also affect immediate family members who seek care at our facility.

The terms of this Agreement shall remain in effect unless/until we modify them. If the Agreement is modified, you will receive a copy of the modified Agreement at your next visit.

I have read and understand this financial policy and agree to abide by its guidelines.

X____ **Date:**______________

Signature of Patient or Responsible Party