Bee Well Urgent Care

BEE WELL URGENT CARE

Date: ___/___/_____

Patient Demographics

Patient Name: _____ Social Security: ___-___-____
Last, First M.

Date of Birth: ___/___/_____ Sex: ☐ M ☐ F Marital Status: _____

Address: _____
Street Address City/ State/ Zip

Billing Address: _____
(If different) Street Address City/ State/ Zip

Home Phone: (___)___-____ Mobile Phone: (___)___-____

Email: _____

Employment and Other Information

Employer: _____ Occupation: _____ Phone: (___)___-____
Company Name Title/Position: Work Phone

Address: _____
Company Address City/ State/ Zip

Spouse/Parental Info: _____/_____ Phone: (___)___-____
Name / Relationship Spouse/Parent Phone

Emergency Contact: _____/_____ Phone: (___)___-____
Name / Relationship Emergency Phone

Referral Information

Referring Doctor: _____ Phone: (___)___-____
Physician Name / Specialty (if known) Physician Phone

Primary Doctor: _____ **Specialist:** _____
(If different) Physician Name / Location Physician Name / Location / Specialty

Date of Injury/Onset: ___/___/_____ **Chief Complaint:** _____

Is your problem the result of a: (Mark all that apply)
☐ Work-Related Injury ☐ Fall ☐ Motor Vehicle Accident: ___/___/_____(date of accident)

Is an attorney involved? ☐ Yes ☐ No *If yes:* Case #: _____
Adjustor Name: _____ Phone: (___)___-____

Insurance Company Information

Primary Insurance: _____ Insured's Name: _____
ID #: _____ Group Name: _____ Group #: _____

Secondary Insurance: _____ Insured's Name: _____
ID #: _____ Group Name: _____ Group #: _____

Worker's Compensation Carrier: _____
Claim #: _____ Case Manager: _____ Phone: (___)___-____

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Office Policies

1. **Failed Appointment Charge**: We reserve the right to charge for every appointment not cancelled within at least a 24-hours before the scheduled appointment time.* **<u>This charge will not be covered by insurance</u>**
   Our Charges are as follows:
   Office Visit $75

When you don't show as scheduled, three people are hurt: You because you don't get the treatment you need, the provider who now has an opening in their schedule; and another patient who could have been scheduled for treatment.

2. **Copayment**- **Patients are required** to pay their co-payments at the time of the office visit. Failure to pay your co-payment could result in denial of service(s). We accept cash, checks and credit cards.

3. Returned Check Charge- All accounts with checks returned from the bank for any reason will be assessed. $35.00 per returned check. **This charge is not covered by your insurance**

4. **Form Completion:** There may be a charge of $ 25.00-$50.00 for each form a patient may request such as: letter to third parties, FMLA, DMV forms, medical narratives and reviews etc.

By Signing this sheet, I acknowledge and agree to the above office policies.

Patient Name (please print)	Patient Signature	Date

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Urgent Care Services-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 incompetently rendered, will be determined by submission to arbitration as provided by Provider law, and not by a lawsuit or resort to court process except as Nevada law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on 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 related to treatment or service provided by the Therapist 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 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 Therapist, and the Therapist's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the Therapist to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must communicate in writing to all parties. Each party shall select an 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, nit supplant, any other applicable statutory or common law.
Either party shall have the absolute right to arbitrate separately the issues 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 proper additional party in a 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 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 Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, 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 once proceeding. A claim shall be waived and forever barred if (1) on the date 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 provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the Provider within 30 days, or signature. It is the intent 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 it is Effective as of the date of first medical services. _____Patient's or Patient Representative's Initials

If any provision if this arbitration agreement is held invalid of 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.

_____ _____
Patient's or Patient Representative's Signature (Date)

_____ _____
Therapist's or Authorized Representative's (Date)

_____ _____
Print Patient's Name (Date)

_____ _____
Print or Stamp Name of Urgent Care (If Representative, Print Name and Relationship to Patient)

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Financial and Practice Policies

It is the policy of Bee Well Urgent Care to collect any money due for all applicable deductible, co-insurance, co-pay's and/or self payments on the date services are rendered as indicated as due and payable by the patients insurance company (if applicable). A receipt will be given for all collection of moneys received in the facility. **It is also the policy of Bee Well Urgent Care to assure that all fiscal obligations are satisfactory for the patient and that every effort is made to assure the patient receives the scheduled care.** Please provide your insurance information to the front desk or the billing department and we will verify your coverage as a courtesy. **Although we are contracted with most insurance carriers, we also accept, and bill plans that we are NOT contracted with**. Being referred to our clinic by a provider does not necessarily guarantee that your insurance will cover our services, that we are a contracted provider with your plan or that we accept the same plans and carriers that your referring physician does. Please remember that you are 100% responsible for all charges incurred: your physicians' referrals, prescriptions and our verification of your insurance benefits are not a guarantee of payment. **Therefore, Bee Well Urgent Care does NOT play any role in how your policy is written by your insurance company.** Do not assume that you will not owe anything if you have more than one insurance policy. If you need special arrangements to be made, please discuss this with the billing manager before starting your treatment.

Please initial your payment method and sign below that you have read, understood and agree with all of the information on this page:

_____**Private Health Insurance (PPO)**: All insurance plans require a referral or prescription with a diagnosis from your physician. Most insurance plans have patient responsibility of a deductible and either a co pay or co-insurance. **Deductibles and co pays are due at the time of services.** We will bill you for co-insurance or other payment due after we have been paid by your insurance or notified of their denial of payment. We can bill your insurance as a courtesy to you.

_____**HMO Insurance**: Authorization from your insurance must be obtained prior to treatment. **Any co pay or co-insurance is due at the time of treatment.** If your HMO plan has a Point of Service (POS) option you are using, please be sure you understand the difference in your POS coverage verses your HMO coverage.

_____**MEDICARE**: Bee Well Urgent Care is a contracted Medicare provider. Medicare has an annual deductible of $240 for Part B **AND** a Co-insurance amount of 20% of the Current Year Medicare rate per visit **If you are currently a patient in a Skilled Nursing Facility or a Home Health Program, Medicare will NOT allow you to see Part B provider until you have been discharged from the program AND the information has been updated with Medicare directly.** Medi gap insurance covers the patients' portion due until your Medicare benefits are exhausted. Some insurance plans that are secondary to Medicare cover the patient portion due and services after Medicare benefits are exhausted, but not always.

___**WORKER'S COMP/PERSONAL INJURY**: **Authorizations from your insurance adjustor is required BEFORE you can begin treatment.** Please provide the billing dept with the name, phone number of your adjustor, the date of your injury, your claim or case number and any other pertinent information.

_____**SELF PAY**: I understand that I will be paying out of pocket and no charges will be submitted to insurance.

_____**Collections**: I understand and agree that I will be RESPONSIBLE for a Collections Fee of 40% of my balance owed if I am sent to a 3rd party collections agency.

Assignment of Benefits/Release of Information/Consent to Treatment

I have read and I agree with the above policies. I hereby authorize/assign my therapy insurance benefits to be paid directly to Bee Well Urgent Care. I also authorize Bee Well Urgent Care to release any necessary information to process my claims. I authorize the release of any medical information necessary to process claims. By signing below, I authenticate that authorization for Assignment of Benefits and Consent to Treatment by Providers at Bee Well Urgent Care. I also understand that I am responsible for all collection and attorney fees incurred to collect my past due accounts

Print Patient Name: _____

Print Parent/Guardian Name (if patient is minor):_____

Signature of Guarantor / Account Responsible: _____Date: _____

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Medical History

Weight: _____ **Height:** _____

Do you smoke? ☐ Y ☐ N _____ (# packs x # years)

Do you drink? ☐ Y ☐ N _____ (# drinks per day/week)

Are you pregnant? ☐ Y ☐ N ___/___/_____ Due Date

How would you rate your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you exercise outside of normal daily activity?

☐ 5+ days/week ☐ 3-4 days/week

☐ 1-2 days/week ☐ Occasionally ☐ None

Have you ever had or been told you have: (MARK ALL THAT APPLY)

Cardiovascular: comment / dates (optional)

- ☐ Heart Disease/Problems _____
- ☐ Pacemaker _____
- ☐ Chest pain/Angina _____
- ☐ Vascular Disease _____
- ☐ High Blood Pressure _____
- ☐ High Cholesterol _____

Musculoskeletal:

- ☐ Fractures/Bone Disease _____
- ☐ Osteoporosis _____
- ☐ Joint Replacement _____
- ☐ Metal Implants _____
- ☐ Back or Neck Problems _____
- ☐ Numbness or Tingling _____
- ☐ Arthritis *Location:* _____

Neurological:

- ☐ Epilepsy/Seizures _____
- ☐ Stroke/CVA _____
- ☐ Headaches/Migraines _____
- ☐ Dizziness _____
- ☐ Peripheral Neuropathy _____

Respiratory:

- ☐ Asthma _____
- ☐ Shortness of Breath _____
- ☐ COPD _____

Gastrointestinal: comment / dates (optional)

- ☐ Hernia _____
- ☐ Reflux/GERD/Ulcers _____
- ☐ Bowel/Bladder Problems _____

Metabolic:

- ☐ Diabetes *Type:* ☐ Pre ☐ I ☐ II
- ☐ Thyroid Disease _____

Kidney/Liver/Blood:

- ☐ Kidney/Liver Disease _____
- ☐ Gallbladder problems _____
- ☐ Hepatitis *Type:* ☐ A ☐ B ☐ C
- ☐ HIV/AIDS _____
- ☐ Anemia _____
- ☐ Easy Bruising/Bleeding _____

Other:

- ☐ Cancer *Location:* _____
- ☐ Glaucoma/Vision problems _____
- ☐ Hard of Hearing _____
- ☐ Skin Condition _____
- ☐ Depression or Anxiety _____
- ☐ Other Nervous Problem _____
- ☐ Unexplained Weight Loss _____
- ☐ Nausea/Vomiting _____
- ☐ Fever/Chills/Sweats _____
- ☐ Excessive Fatigue/Weakness _____

Please list/describe:

Other Medical Conditions/Diagnoses (not included above): _____

Allergies (please include reactions): _____

Previous Surgeries (please include date): _____

Current Medications: _____

(If Medicare, please provide copy of medication list including dosage, or fill out attached form)

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Medication List

Patient Name: _____

DOB: ___/___/_____ **Height:** _____ **Weight:** _____

Please list ALL medications including prescription, over the counter, herbals, vitamins & supplements.

	Medication Name	**Dosage & Frequency**	**Route of Administration** (Oral, Nasal, Injection, etc.).
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			