PLEASE PRINT CLEARLY

GENERAL INFORMATION

Patient Last Name_____ First Name_____

Email_____

Parent/Guardian (if patient is a minor under the age of 18)_____

Phone (Cell) _____ Phone (HM) _____ Phone (Work)_____

Address_____

City_____ State_____ Zip_____

Check one: ☐ M ☐ F ☐ Married ☐ Single ☐ Widowed ☐ Divorced

DOB_____/_____/_____ SSN_____-_____-_____

Race _____ Ethnicity _____ Primary Language _____

Primary Insurance Policy Holder: Name_____DOB_____

Are you an Erlanger Employee: Yes ☐ No ☐

Are you an established Erlanger patient: Yes ☐ No ☐

REASON FOR VISIT:_____

PRIMARY CARE DR: _____

EMERGENCY CONTACT:_____**PHONE#:**_____

PREFERRED PHARMACY:_____

How did you hear about us? _____

Consent for Treatment/Acknowledgement of Privacy/Acknowledgement of Financial Policy:

I, the undersigned, consent to the care and treatment by the attending Physician/Provider at Erlanger Express Care, his/her associates or assistants and acknowledge that no guarantees have been made as the outcome of such treatment.

I acknowledge that Erlanger Express Care's Patient Bill of Rights and Notice of Privacy are available upon my request at the reception area.

I acknowledge full financial responsibility to any services received and that the payment of charges incurred in this office is due at the time of service. I also understand that the charges not covered by insurance remains my responsibility. If my account is turned over to a collection agency, I agree to pay all late fees, costs of collection fees and /or Attorney's fees and all court cost, if any. I understand that any services not provided directly by Erlanger Express Care (labs/outside imaging) are a separate charge and will be billed by the provider of those services.

In order for us to service your account or collect any amount owed to us, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which may result in additional charges from your phone carrier. We may also contact you by sending an email to the email address you have provided.

Patients Signature Date

Credit Card/Debit Card Authorization

Erlanger Express Care submits claims to insurance carriers as a convenience to all our patients. At this time, we request authorization to balance bill a major credit card or debit card to cover amounts determined by your insurance to be your responsibility.

Upon receipt of an explanation of benefits from your insurance carrier, any unpaid portion of your claim will be billed to your credit card or debit card. Should insurance pay in full, your account will not be charged.

All credit card/debit card information will remain absolutely confidential and securely stored by **First Data**. Erlanger Express Care will not store any banking account data. This payment will not be used for any previous and/or future charges, only for today's visit.

I hereby authorize Erlanger Express Care to charge any and all outstanding balances, after insurance company reimbursement or denial, to my credit/debit card. I understand that I will not receive a statement if there is no balance due after processing my credit card for payment.

Acount Type: Visa MasterCard AMEX Discover	**Office Use ONLY**
Cardholder Name: _____	Patient ID:
Credit Card # (last 4 digits): _____	
Cardholder Address: _____	

_____ _____

Cardholder's Authorization Signature **Date**

Our billing department will send you an email approximately seven days before prior to charging your credit/debit card for the remaining patient responsibility. Please legibly print the email address below where you would like to receive this notification. If this email is not valid, you may not receive the notification and your card will still be charged.

_____

Email

PATIENT'S AUTHORIZATION

Use & Disclosure of Protected Health Information

_____ _____

Name of Patient Date of Birth

I hereby authorize Erlanger Express Care to use or disclose the protected health care information of the listed patient for the specific purpose explained below.

I understand that I have the right to revoke this authorization at any time. The revocation must be in writing and must be submitted to the listed health care provider. Exceptions to the right to revoke exist.

THE FOLLOWING INFORMATION THAT I HAVE SELECTED:

TEST RESULTS _____ APPOINTMENTS _____

PRESCRIPTIONS _____ FINANCIALS _____

MEDICAL RECORDS _____

MAY BE RELEASED TO THE FOLLOWING PERSONS:

(List any doctors, family members, or friends you wish to include.)

The selected items above may be released only to the persons listed below:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Signature of Patient Date

OR

_____ _____

Signature of patient's personal representative Date

Describe the personal representative's authority to act for the patient:

_____

Patient Consent to Receive SMS Messages; Recording Policy

Visit Follow-up Communication

TEXT MESSAGE AND INFORMED CONSENT: In order to enhance patients' care and experience, Erlanger Express Care may contact you after your visit in order to request feedback on your experience. This contact may be by phone, text message, e-mail, voicemail, or mobile application, some of which may be by automated means. By signing below, you understand and agree to be contacted in this manner with communications related to this visit, and any future visits. In the future, you may opt-out of receiving text messages by notifying us in writing (including responding via text message). Standard telephone minute and text charges may apply if we contact you.

In addition, based on your potential feedback, we may identify statements or comments that might help other potential patients choose to receive their treatment with us. By signing this consent, you acknowledge and agree that these comments and/or statements may be used on an anonymous basis on our website only, purely for providing those who may view the website with objective reviews of our care.

MOBILE SAFETY TIPS: While we work hard to protect your information, remember that electronic communication is never 100% secure. It's very unlikely, but information you send via text, email or mobile application, or that you leave on your mobile device, could be exposed to people other than your doctor. Here are a few safety tips to follow:

1. Use a password on your mobile device to prevent strangers from seeing what is on your phone.
2. Limit the amount of sensitive health information you send. You can always call your provider to discuss something private or sensitive.
3. If you are worried about those close to you seeing your messages, you can delete them from your email or messaging app. This won't erase them completely but will make it hard for others to see them.

I understand that in order to protect the privacy of our patients and workers, the use of recording devices (video or audio) is strictly prohibited while visiting Erlanger Express Care.

_____ _____

Signature of Patient Date

OR

_____ _____

Signature of patient's personal representative Date

Describe the personal representative's authority to act for the patient:

_____

MEDICATION LIST

Medication Name	Dosage/mg	How often?	Reason

Allergies:_____

Patient Signature _____ Date _____

Thank you very much for choosing us to provide your urgent care needs today. Please know that we also feel it is important that patients have a primary care physician.

If you do not have a primary care physician and would like to get one, please consider the resource below.

Visit www.erlanger.org

Call 423-778-DOCS

Thank you.

Your Erlanger Express Care Team

Please keep this form for your records.

COVID-19 Assessment

At Erlanger Express Care, the safety and well-being of our patients and employees is our highest priority. In accordance with the CDC and state department of health, we ask your cooperation to complete this simple questionnaire. All information will be kept confidential.

Name:_____

Do you currently, or in the past 7 days, have you had any of these symptoms? (Circle answer)

Yes No 1. Fever greater than 100.4^{o}F

Yes No 2. Cough

Yes No 3. Shortness of breath

Yes No 4. Body Aches

Yes No 5. Loss of Smell or Taste

Yes No 6. Nausea, Vomiting, or Diarrhea

Yes No 7. Been in contact with a person with confirmed COVID-19 in the past 14 days

If you answered yes to 2 or more symptoms above, please see the receptionist. We will need to see you today via a telehealth visit.

_____ _____

Signature Date

OFFICE USE ONLY: TEMP_____ REVIEWER INITIALS_____