IMMEDIATE CARE MEDICAL CENTER
A PROFESSIONAL CORPORATION
CHICO • ORLAND

PREMIERE PRIMARY CARE

Registration Form - please print

Current Patient Information Demographics	
Patient Name (legal) Last Name: _____ First Name, MI: _____ Preferred Name: _____ DOB: _____ Age: _____ Sex: M or F Pronouns: _____ Mobile Phone:_____ Home Phone: _____ Mailing Address: _____ Apt # _____ Zip Code: _____ City: _____ State:_____ Email address: _____ SSN: _____ Driver's License: _____ **Patient Representative, if applicable** Legal Name (Last, First, MI): _____ Relationship to Patient:_____	Primary Care Provider:_____ Preferred Pharmacy:_____ Marital Status: _____ Sexual Orientation: _____ Preferred Language: _____ Employment Status: _____ Ethnicity:_____ Do you identify as Hispanic/Latino? Y or N Race: [ ] Asian [ ] Black/African American [ ] Native American [ ] White [ ] Other:_____ **Emergency Contact** Name of Contact: _____ Phone Number: _____ Relationship to patient:_____

We will need a copy of your ID and insurance card on file prior to being seen by a medical provider

Insurance Information	
Primary Insurance	Secondary Insurance
Insurance Co.: _____ Policy ID No.: _____ Subscriber Name: _____ Subscriber DOB: _____ Sex: M or F Relationship to Patient:_____	Insurance Co.: _____ Policy ID No.: _____ Subscriber Name: _____ Subscriber DOB: _____ Sex: M or F Relationship to Patient:_____
Are you being seen for a work-related injury/illness? Y or N Date of injury: _____ If yes, who is your employer? _____ Employer Phone No.: _____	

To the best of my knowledge the above information is complete and accurate.

Patient/Representative Signature: _____ Date: _____

Representative Name (printed): _____ Relationship to patient:_____

I authorize Chico Immediate Care Medical Center Inc. to contact me by mobile phone on file.

Patient/Representative Signature: _____ Date: _____

Representative Name (printed): _____ Relationship to patient:_____

(Office Use Only) Initials _____ / _____

Financial Policy

It is the policy of Chico Immediate Care Medical Center Inc.to request payment in full at the time of service. Acceptable payments include cash check, credit card (excluding american express). Current insurance is acceptable, and as a courtesy, Chico Immediate Care Medical Center Inc.will bill the insurance company for reimbursement. I hereby assign my insurance benefits to be paid directly to the healthcare provider. If payment of the account has not been made by either the patient or the Insurance company, within sixty (60) days, the patient is expected to pay the balance in full. Regardless of insurance coverage the patient is expected to pay (at time of service) any copays, unmet deductibles, charges for pharmaceuticals and all charges not covered by the policy.

Quest Diagnostics and Valley Clinical may be used for all outside laboratory services unless prior arrangements have been made. Except for companies with which we have agreements, our office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. Regardless of any claim pending, if there is an open balance, a statement will be sent to you. Should the account be referred to an attorney or collection agency (TSI collections) for collection, the undersigned shall pay accrual of attorney's fees and collection expenses. Your signature Indicates that you are aware of Chico Immediate Care Medical Center Inc.'s payment policy and gives permission to Chico Immediate Care Medical Center Inc. to bill your insurance, release any information necessary for billing and receive payment directly from the same. Chico Immediate Care Medical Center Inc. does not accept Medi-Cal or CA Health and Wellness patients. Should you obtain Medi-Cal or CA Health and Wellness as your primary or secondary insurance while being treated at this office, we will no longer be able to accept you as a patient at Chico Immediate Care Medical Center Inc.

It is the policy of Chico Immediate Care Medical Center Inc. to charge a "missed appointment" fee for any appointment that you miss or do not cancel 24 hours prior to the appointment. This fee will be $25.00 and will be the responsibility of the patient directly, it cannot be billed to insurance. Three "missed appointments" may result in dismissal from our practice. By signing below you are stating that you have read and agreed to the terms of the "missed appointment" fee.

Patient Financial Responsibility

Any and all laboratory tests and specimens (titers, urine cultures, throat cultures, etc.) sent to an outside lab (Quest, Valley Clinical, PSMG, Ethos) will be charged to the patient's health insurance. If the patient does not have health insurance, all acquired costs are billed directly to the patient, and are the financial responsibility of the patient.

I understand that I will receive a bill from one of the labs listed above, and I am responsible for making payments in full for any and all services received. I understand that I am responsible for any charges that I incur by choosing to utilize the services of Chico Immediate Care Medical Center Inc. By signing below, I confirm my understanding of the above information and my consent to the above disclosures

I have read the above statement and I understand and agree to Chico Immediate Care Medical Center Inc.'s financial and patient responsibility policy.

Patient/Representative Signature: _____ Date: _____

Representative Name (printed): _____ Relationship to patient:_____

Consent to Treatment and Acknowledgment for Follow-Up Care

I, the patient, consent to evaluation and/or treatment of the condition for which I or my dependent, has come to Chico Immediate Care Medical Center Inc. I consent to physical examinations, injections, collection of laboratory specimens, venipuncture, and all other testing deemed necessary, and jointly agreed upon by my provider during a visit with Chico Immediate Care Medical Center Inc. I agree to ask any and all questions before injections given, laboratory specimens are collected, and/or appropriate testing is performed. I acknowledge and agree that this consent will be kept on file and applicable to all visits, emergency care, or episodes of treatment and evaluations by Chico Immediate Care Medical Center Inc. until revoked.

I am aware that blood and other potentially infectious body fluid exposures sometimes occur in health care settings, such as an accidental needle stick or blood splashing into the eyes or other mucus membranes of another person. If my blood, or other potentially infectious body fluids, should expose an employee of any Chico Immediate Care Medical Center Inc. facility while they are caring for me, I agree to have my blood drawn in order to be tested for HIV, Hepatitis B, and Hepatitis C. The results of the tests will be made known to the exposed employee, but the results will otherwise be kept confidential, as per HIPAA requirements

I acknowledge that I will be responsible to follow up with a medical provider at this clinic in order to discuss any procedures/labs/referrals that were ordered during my visit. Follow-up visits will be considered another office visit and I may be subject to out-of-pocket costs or copays. Follow-ups can be conducted via a telehealth video, over the phone, or in the clinic. The provider may determine which type of follow up is acceptable, based on the type of follow-up care needed. I, the patient, may pick up a copy of any reports/results after I sign an authorization form that is provided by the clinic. I may access my reports/results on Athena Patient portal. If I have any questions and want to discuss results with the medical provider, I understand it is my responsibility to seek a follow-up visit. If I choose not to review my results with a medical provider, I take responsibility for any negative, and potentially serious, consequences to my health.

I have read the above statement and understand and agree to Chico Immediate Care Medical Center Inc.'s consent to treatment and acknowledgment of care.

Patient/Representative Signature: _____ Date: _____

Representative Name (printed): _____ Relationship to patient:_____

HIPAA Privacy and Release of Information Authorization

I, _____, hereby authorize Chico Immediate Care Medical Center Inc. and its affiliates, its employees and agents, to use and disclose protected health information (eg information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues. I authorize Chico Immediate Care Medical Center Inc. to obtain/have access to my medication history and share my medical records with other healthcare facilities that I am currently receiving care from.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. I consent to release information to CAIR (CA Immunization Registry). I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form. I am aware that I have the right to a copy of Chico Immediate Care Medical Center Inc.'s Notice of Privacy Practices. I consent to the uses and disclosures of my health information as outlined in the Notice.

Authorization to Release PHI to family members, friends, and/ or Caretakers

I acknowledge and agree that Chico Immediate Care Medical Center Inc. may use or disclose Protected Health Information to the person(s) I have indicated below. This information will include office notes, diagnostic tests and financial history reports unless I state otherwise.

1. Full Legal Name (printed) _____
   Date of Birth _____ Relationship to patient: _____
2. Full Legal Name (printed) _____
   Date of Birth _____ Relationship to patient: _____
3. Full Legal Name (printed) _____
   Date of Birth _____ Relationship to patient: _____

I have read the statement above and understand the HIPAA/Privacy Policy for Chico Immediate Care Medical Center Inc.

Patient/Representative Signature: _____ Date: _____

Representative Name (printed): _____ Relationship to patient:_____

☐ I refuse to allow the release and/or disclosure of my protected health information.

Patient Signature: _____ Date: _____