Office use only:

**Clinton Urgent Care, Inc.**

"Please **read carefully** all the sections of this form **before you sign it**."

*1) PATIENT INFORMATION "(please fill out this section every visit)"*

**Are you having an emergency at this time?** *(Write yes or No)*_____

If the answer is **"yes"**, then **stop** now and **request emergency help immediately!**

I verified all the information provided. Employee initials: _____

| | |
|---|---|
| **Today's Date:** | **Date of Birth:** |
| **Name:** | |
| **Address:** | **Social Security #:** |
| | **Sex:** **Marital Status:** |
| **City:**<br>**State:** **Zip:** | **Employer:** |
| **E-mail address:** | **Spouse Name:**<br>**DOB:** |
| **Home Phone#:** | **Emergency Contact:** |
| **Work Phone#:** | **Emergency Phone#:** |
| **Cell Phone#:** | **Emergency Relationship:** |
| **Reason for today's visit:** _____<br>☐ Motor Vehicle Accident ☐ Workers Compensation Claim<br>☐ Physical ___School ___Sport ___DOT/FAA ___ | **Medications that you are taking:** _____<br>**Pharmacy Name:** _____<br>**List all doctors and facilities you have been seen before:** _____ |

*NO REFILLS WILL BE AUTHORIZED ON WEEKENDS, HOLIDAYS AFTER HOURS OR AS AN "EMERGENCY", SUCH AS FRIDAY AFTERNOON BECAUSE I SUDDENLY REALIZED THAT I WILL "RUN OUT TOMORROW" I MUST KEEP TRACK OF MY MEDICATION AND PLAN AHEAD FOR A VISIT TO THE DOCTOR. NO REFILLS WILL BE MADE OVER THE PHONE. NO REFILLS WILL BE AUTHORIZED BY PRODUCING A POLICE REPORT. LOST / STOLEN MEDICATIONS WILL NOT BE REPLACED.

| | |
|---|---|
| ☐ I need a school / work excuse. | ☐ I would appreciate a prayer today. |
| **Race:**<br>☐ American Indian / Alaska Native<br>☐ Asian<br>☐ Black /African American<br>☐ Native Hawaiian<br>☐ White<br>☐ Other Pacific Islander<br>☐ Refused to Report / Unreported<br>☐ More than one race<br>☐ Primary language: _____ | **Ethnicity:**<br>☐ Hispanic or Latino<br>☐ Not Hispanic or Latino<br>☐ Refuse to Report<br><br>**Receptionist Notes:** (Office use only) |

*2) INSURANCE INFORMATION* **NEW INSURANCE?* *Yes* ☐ *No* ☐

| **PRIMARY INSURANCE:** | **SECONDARY INSURANCE:** |
|---|---|
| **Policy#** | **Policy#** |
| **Group Number:** | **Group Number:** |
| **Group Name:** | **Group Name:** |
| **Co-pay:** | **Co-pay:** |
| **Subscriber Name:** | **Subscriber Name:** |
| **Subscriber Date of Birth:** | **Subscriber Date of Birth:** |
| **Subscriber Social Security #:** | **Subscriber Social Security #:** |
| **Effective Date:** | **Effective Date:** |

*3) GUARANTOR / RESPONSIBLE PARTY INFORMATION (please let us know about any changes)*

| | |
|---|---|
| **Name:** | **Date of Birth:** |
| **Address One:** | **Social Security #:** |
| **Address Two:** | **Work Contact Name:** |
| **City:** | **Employer Company Name:** |
| **State:** **Zip:** | **Employer address:** |
| **Home Phone#:** | **City:** |
| **Work Phone#:** | **State:** |
| **Cell Phone#:** | **Zip:** |



*(Continue next page)*

*** I acknowledge that the Clinton Urgent Care Privacy Notice has been posted for my review and that, if I ask, a copy for my own records will be given to me.**

***Authorization to pay Benefits to Physician:** I authorize the release of medical or other personal information to process health insurance claims. I also request payment of benefits to Clinton Urgent Care, Inc, when assignment is accepted.

***I understand that I am responsible for all charges whether or not paid by insurance.**

***I authorize the use of this signature for insurance submissions.**

***Authorization to Release Medical Information:** I hereby authorize Clinton Urgent Care, Inc. to release and/ or Request any information necessary for my course of treatment including but not limited to medical records from other doctors and /or facilities.

***Authorization to Leave Phone Messages:** I hereby authorize Clinton Urgent Care, Inc. to leave messages over my home phone number regarding my medical care.

***I authorize my Pharmacy** to release my prescription history to Clinton Urgent Care Inc. whenever it's needed.

***I, the Patient/ Guardian, agree** not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against Dr Osaro, MD, Clinton Urgent Care, Inc, Clinton Urgent Care, Inc. staff.

*Should I initiate or pursue a meritorious medical malpractice claim against Dr Osaro, **I agree** to use as expert witness only physicians who are board certified by American Board of Medical Specialties in the same specialty as Dr Osaro, MD. Further, I agree that these physicians retained by me or on my behalf to be expert witness will be members in good standing of the ABFP *(American Board of Family Physicians)*

***I irrevocably agree** to submit any and all claims against the Clinic to arbitration rather to a judge or jury.

***I irrevocably agree** to limit any claim relating to any diagnosis, treatment or care by the Clinic to $250.000 for all non-economic damages, including pain and suffering or inconvenience. In the event I assert a claim against the Clinic and it is denied, then I agree to pay for the reasonable attorney and expert fees of the Clinic's defense.

***Copyrights/Privacy agreement.** Federal and Stated privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, physicians are forbidden by law from receiving money for selling list of patients or medical information to companies to market their products or services directly to patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Dr. Osaro, MD believes this is improper and may not be in the patient's best interest. Accordingly, Dr Osaro, MD agrees no to provide medical information for the purpose of marketing directly to Patient. Regardless of legal privacy loopholes, Dr Osaro, MD will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

Dr, Osaro, MD has invested significant financial and marketing resources in developing the Practice. Nothing in this Agreement prevents a patient from posting commentary about the physician-his practice, expertise, and / or treatment-on web pages, blogs and /or mass correspondence. In consideration for treatment and the above noted patient protection, if the Patient exclusively assigns all intellectual Property rights, including copyrights, to Dr. Osaro, MD for any written, pictorial, and/or electronic commentary.

This agreement shall be in force and enforceable for a period of five years from Dr Osaro's/Clinton Urgent Care, Inc,/ Clinton Urgent Care, Inc staff last date of service to Patient. Further, this agreement will survive for a minimum of three years beyond any termination of the physician-Patient relationship.

***Patient/guardian and Dr Osaro agree** that all the above Agreements are binding upon them individually and their respective successors assigns, representatives, personal representatives, spouses and other dependents.

***By Signing below, I certify that all the information that I have provided is true and accurate and that I understand all of the above and I have been given the opportunity to ask questions and receive satisfactory and adequate explanations. I also agree that a copy or a scanned version of this document signed by myself or my representative is as good and legal as the original.**

***Patient Signature/ Legal Guardian:** _____ **Today's Date:** ___/___/___

*** Legal Guardian/ Personal Representative** (Print Name): _____ **Phone#:** _____

***Relationship to Patient:** _____

***Signature** of Person responsible for this account) **(if other than above):** _____